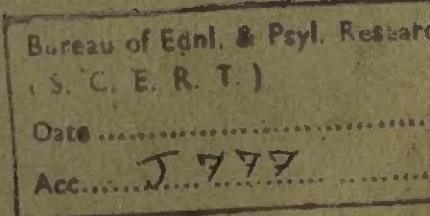# THE
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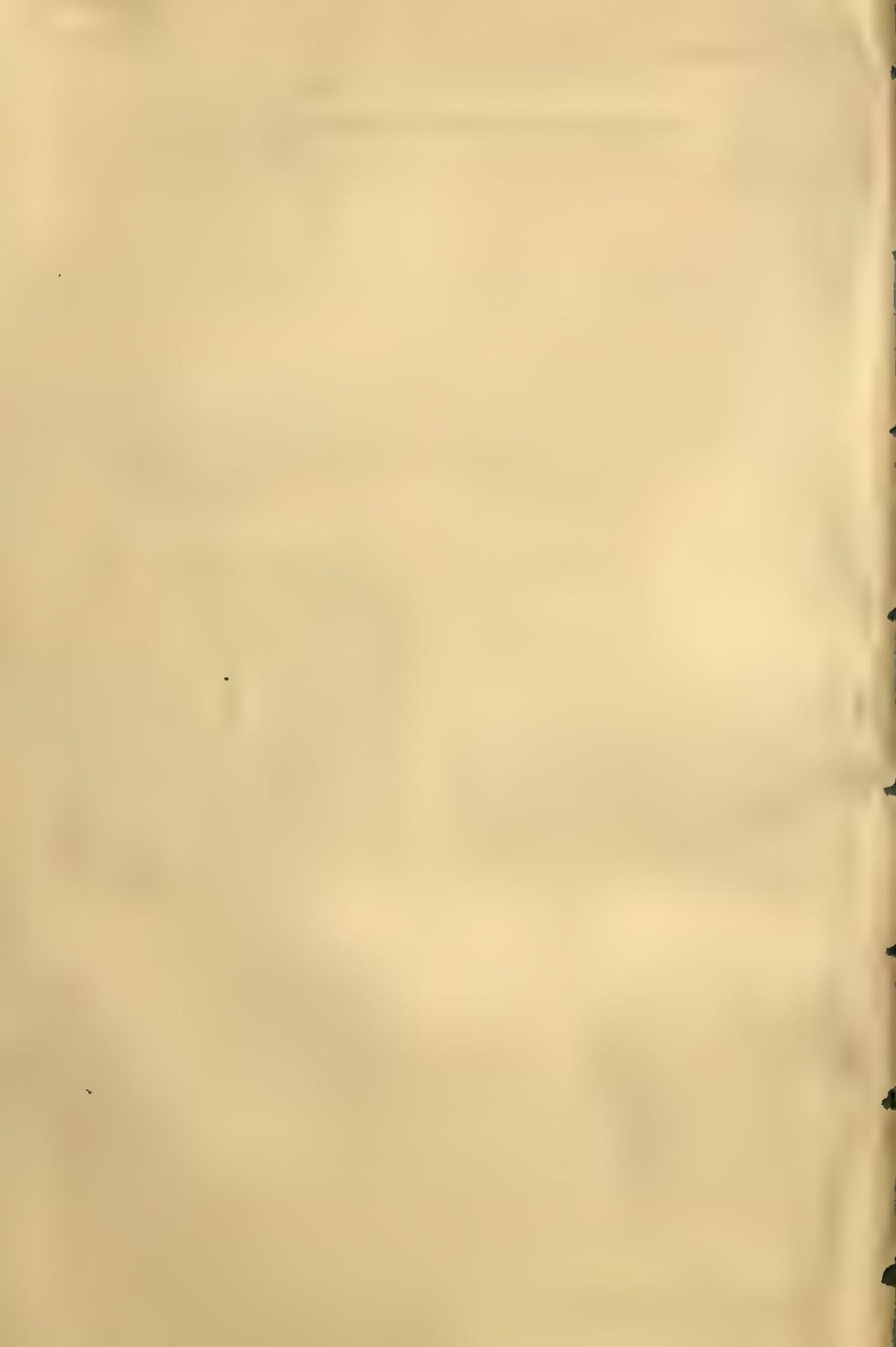
Regression as therapy illustrated by the case of a boy whose pathological dependence was adequately met by the parents

BY D. W. WINNICOTT (London)

These case notes concern a boy, a characteristic of whose emotional development was a capacity to regress to dependence in his home setting. The parents met these regressions adequately, and in this way turned them into positive therapeutic experiences.

The case has special interest in that the process links very closely with the regressive episodes that characterize the life of any child in a reliable home setting, that is, apart from the question of psychiatric illness either in the child or in the family.

The management of this case was based on six consultation hours spaced as follows:

Age of boy (born Oct. 1953)	
12 July 1955	21 months
12 Oct. 1955	24 months
8 Feb. 1956	28 months
6 Feb. 1957	3½ years
Gap	
17 Oct. 1961	8 years
1 Feb. 1962	8 years

Cecil was referred to me in my private practice by the teacher at his nursery school in a district outside London.

CONSULTATION WITH THE FATHER, 12 JULY 1955

I first interviewed the father, who was genuinely concerned about his child and had a good grip on the total situation. In an hour's interview he told me the details of Cecil's life.

Family. There were two children of the marriage, Cecil, 21 months, and Kenneth, 1 month, who was being breast fed. The father described the mother as 'intelligent but not always easy'. Cecil was born normally (7 lb.) and had been breast fed for 8 months. He was eager and had been fed 'on demand'. He had been in fact rather greedy, and would tend to wake after one hour, so that from 6 weeks old he was not a good sleeper. For this he was taken to a hospital clinic and given chloral. On the whole he was happy and started early to play. He became easy, and weaning at 8 months presented no difficulty.

The father said that his wife had been more competent with Kenneth, who did very well from the start, than she had been with Cecil, implying that there was real difficulty with Cecil in the early weeks. At 10 months Cecil was piling bricks one on top of another. He sat and walked in good time. At 21 months he was not using words.

Onset of symptoms. The father then tried to describe the difficulty about which he was consulting me. He said that Cecil changed in *November 1954* at the age of 13 months. He related this to the fact that his wife had become pregnant in the previous month and she was *liable to be anxious when starting a new pregnancy.* At 13 months, therefore, Cecil began to go back to what the father described as his baby difficulties, the sleeplessness in particular, and in general a lack of confidence in the mother, and it became necessary for either the father or the mother to be actually with him. At the same time he began to lose his interest in toys. Each night he would wake several times and either the father or the mother would go to him. When he woke, he woke screaming. On the credit side, he was feeding well and growing at the proper rate, and an interest in music had appeared.

Use of pot. In regard to the use of a pot Cecil had become able to use the pot if want-

ing to do so, but in this phase (which started when he was 11 months old) Cecil had given up using it altogether. He was not having nappies but was wetting when he felt like it on the ground. The parents were not strict about this.

The second child was born at home 5 weeks before this consultation with the father. Cecil then being 20 months old. During the 5 weeks prior to the baby's birth Cecil's symptomatology had got worse, especially in the matter of his difficulty in going to sleep, and his waking screaming, and he had started to resist going to bed. The night before the consultation he had cried for three-quarters of an hour, pushing everything away, stamping his feet and striking himself. He would have attacks of this kind every day or so, and perhaps two a day.

Before the baby came the parents tried to tell Cecil what to expect, but he did not understand as far as they knew. When the baby came, he was 'not interested in him', or he would look at him and poke his nose or ears, and lead his parents off to look at something else. At the same time he himself wanted to get into a pram or a cot.

Transitional phenomena. The father told me, when I made routine inquiries, that Cecil had first sucked his fist and then one thumb, but only on going to sleep. He never liked to have any special object. During the past month, however, that is to say since the birth of the baby, he had been sucking his thumb all day and especially if the baby was being fed. Cecil had not actually tried to get to the breast but he had been very pleased to feed at the same time that the baby was being fed. The father reported that play had now almost ceased. Water and sand were neglected, and toys had become unimportant. At times he would mope and sit sucking his thumb. On the other hand he had developed his new and very positive interest in music, and he liked to do housework, pretending to wash up and to use the Hoover.

The general practitioner was helpful in the management of Cecil, but the time had come

when drugs no longer made a difference to Cecil's state.

At this stage in the consultation I realized that I had been consulted over the telephone by a colleague in regard to the management of this very case. The father told me that this doctor had advised him and his wife to employ a nurse for Cecil. It amused me to find that when I strongly contradicted this advice I was contradicting myself, and this showed me how different is the advice that one can give at a distance from the way one acts when one is in actual contact with a case. The parents had tried using a nurse but very soon Cecil had refused to let her supplant the parents, although he seemed to be fond of her.

Comment. Now that I was in direct contact with the case I found myself entirely caught up in the idea of enabling these parents themselves to deal with their child's illness. I took into account the fact that along with all these troubles Cecil was affectionate and rather sweet-natured, and he was even becoming loving towards the baby boy. He was able to make positive use of sleeping in the parents' bed, except when he had one of those bouts of crying, at which times nothing was of any use.

The father suggested that the pattern of the very early infantile disturbance of the first few weeks had seemed to be reactivated in detail in this new period which started in November along with the beginning of the mother's anxiety about her pregnancy.

After this consultation I wrote the following letter to my colleague:

This child, who started to change last October at the moment when the mother learned she was pregnant (she always becomes more anxious when pregnant) is in a rather seriously depressed state, but his appetite and general health are not very much affected, and of the two parents the father, at any rate, seems to be able to meet this child's needs. I am sure that we would agree with me that handing the child over to a nurse would be a good thing only if the parents were actually failing. It must be a matter of opinion whether one can say that there is a failure now in the meeting of the child's special needs. I am

presuming that the parents are not failing the child at present and that they may be able to bring the child through the present illness.

I have no doubt whatever that the child who does not enjoy a sound its feed of the baby, and who is fond of the baby, was nevertheless seriously affected by the mother's change of attitude last October when she became pregnant.

These parents would consider psychotherapy for the two boys although this would mean a considerable disturbance of the household routine. I have suggested that the whole matter shall hang over until after the holiday.

On 14 July 1955 I received the following letter from the father.

Your advice about Cecil has helped us to feel more confident that we may be able to help him ourselves, as we want to do. We will write again about 20 August as you suggested.

This letter confirmed the idea that I had formed that he and the mother wished to deal with Cecil themselves if I would help them to do so. I expressed in the following letter on 15 July:

I feel sure now, however, that if you your-selves are able to see Cecil through this will be much more satisfactory all round than getting outside help. On the other hand we must not be afraid to take the other line if it is necessary. It is mere speaking to say that I have felt the encouraging you to try to do it yourselves.

In the father's letter of August he reported progress giving just the kind of detail that I asked to know.

You will remember you asked me to write to tell you how our son Cecil was getting on once I see you in July.

For the last 3–4 weeks he has been happier much of the time, with more days when he is reasonable. I stop chasing, nagging and generally is expecting of him to a domestic routine. I sleep in bed with him. He was waker in the night now at times now sometimes getting out of bed and crying, but for a shorter time than previously. In the morning and after a midday sleep when wide he now wakes and I ... even without crying. He does not get back to sleep but tries to get at and out of bed several times, often going to sleep on the floor.

He plays more than he did, he is still passionately fond of music and dances to it, he is now keen on looking of picture books. He will draw me and has makes a wider range of sounds.

He is sometimes very nervy and coughing and at other times he is very quiet and will fix long and then he sucks his thumb. He often looks pale and tired.

I should be very glad if you could see Cecil and my wife. We are anxious to know if he should have treatment or whether you think he may grow up happily without it. I am very keen that my wife should see you as I think she has an unnecessary loss confidence and I think it would be of great help if you could give her a general picture of the situation.

After this I arranged to see Cecil's mother.

CHILD'S FATHER WITH THE MOTHER, 13 OCTOBER 1955

The mother brought Cecil who slept almost throughout the consultation on her lap. At this time he was 2 years old and his brother was 4 months old.

The mother gradually told me her version of the story which was very similar to that given by her husband. She said that Cecil was more happier and weeping better. Occasionally he would scream, or lose in some other way, at the time of the feeding of the baby who was also on the breast.

She then spoke of the changes in Cecil for which they were consulting me. He had placed in a normal way of a way before he was a year and but then had lost capacity.

At this point in the consultation I was able enough to extend his hand so that a finger was in his mother's mouth when he was sucking his own thumb.

The mother went over the details of what happened in November two months after the consummation of Kenneth when she was not really feeling well and when Cecil about 11 months old began to alter. Cecil gave up using the pot and he wanted to be like a baby, wetting the pram and he insisted on being finished as the was that babies are finished. In his pressing he wanted to be making the cot up

in the way that his mother has to make it up for a baby, and now (at 2 years) he does this with a doll. Sometimes recently (the mother said) he has become angry, hitting the baby and the mother. She recognized this as an improvement on the other technique whereby he became a baby himself. The mother said that she was very much occupied with the new baby, and Cecil had resented this at first. Cecil had been able to use his father in an affectionate way when in a state of strained relationships with herself. Now (at 2 years) Cecil was enjoying himself but not, however, playing on his own, that is to say, not using toys in the way that he used to do before he became ill. He had become 'almost obsessionally' clean, and very pleased to be allowed to help in housework and cooking. He could dress himself with a little help and he was eating normally.

In answer to my inquiry the mother told me that Cecil had had a teddy from early infancy but that this had never meant very much to him. He now had a gollywog which had become important to him in a special way. 'He talks to it', she said, 'making noises for it, putting it to bed and feeding it at the navel.'

Her chief complaint about Cecil now was that he was not talking. He made himself understood, however, and understood everything. There were no children available for him to play with.

Cecil had good muscle tone and had now begun to like having a bath again, playing with the taps, and playing with water in the sink.

Strangers in the house made him anxious and he would stand by his mother sucking his thumb, not making contact with the strangers. The mother said that the father had never been angry with Cecil; he was very long-suffering. All the week with the father away Cecil tended to whine and the mother interpreted this as a longing for the father, and this fact made her annoyed sometimes. She might prefer it if the father were more firm, because troubles tended to appear when the father was away, and when the father was present Cecil went to him instead of to the mother. When Cecil woke crying at night he would tend to cling to his father rather than to her.

I followed up this consultation with a letter to my colleague on 13 October:

A further note about this child—He is not yet talking. On the other hand there are many signs of improvement, and I think that the mother is coping satisfactorily with the difficult problem of bringing the older child round while bringing the baby up. Cecil is gradually emerging from his need to be like the baby and has even been able to express anger with the baby and the mother when they were together. Partly he is solving his problem along the lines of identification with the mother, being preoccupied with housework, which he does quite well, and with treating his dolls exactly as the baby is treated. One good sign is that he has now for the first time adopted an object, a gollywog, and he is also becoming interested in his teddy which he has had from early times but in which he has not previously been interested. He still sucks his thumb at appropriate moments.

He seems happy and able to enjoy the company of the temporary nurse. He is obsessed with cleaning and playing with water. He dresses himself, nearly. He is eating well. There is an almost complete absence of play with toys, and this remains as a major symptom, and it is quite clear that he was playing with toys up till last November when he became ill in reaction to changes in his mother.

He came to me asleep and stayed asleep during most of the consultation. Without quite waking he did put his finger in his mother's mouth while he had his thumb in his own. In the end he woke and behaved like an intelligent child. He was still sleepy but he played with a toy I gave him and took it away. He has never yet spoken a recognizable word, but he talks to his dolls in his own language and he understands everything and makes himself understood.

He is fairly well established in his body and I think his muscle tone is not flabby.

I think you will see from these notes that the risk I took in advising the mother to look after this child may prove to be justified. There is still a sleep disturbance but usually this amounts to his waking once, which is not too bad. He goes to sleep happily and wakes happily in the morning.

A major factor corresponding to the mother's nerviness is the father's gentle nature. It is difficult for the father to give directions or to be angry. The mother says that if anyone has to be angry ever it has to be herself. In this way weekends are the worst time, with father at home and the child whining all the time, clinging to his father and pushing mother away. During the week, with father away, he is not difficult and he is usually not whining but appears to be happy.

There is a long way for this child to go yet, but I think he might become normal if we use the word normal in rather a broad way.

INTERVAL—OCTOBER 1955 TO FEBRUARY 1956

I next saw the mother, who again brought Cecil, on 8 February 1956. The father came too.

It was reported that the baby (8 months old) had had eczema, but was otherwise well and still being breast fed. Cecil (now 2 years 4 months) was on the whole happy. He had started using words of one syllable.

While I was talking to the parents Cecil was sucking his thumb and keeping his other hand in his mother's bag.*

It was reported that Cecil was playing more, but all the time watching to make sure his mother was there and ready to be attentive to him. He had evinced a slight interest in the baby, occasionally even being affectionate towards him, but at other times showing that the baby was a nuisance to him. Meals had become more peaceful. He was no longer insisting on having his meals with the parents. An affectionate relationship to the mother had returned, but the very positive relationship to the father remained. He was now able to be happy with father and mother together, and was able to allow the father to leave him without becoming distressed. He had now been using the pot again for defaecation.

Cecil had now become able to communicate complex ideas or orders. For example, he would show his undone shoelaces; if the

mother did not do them up he would say: 'Undone!'

At this point in the consultation Cecil was discovering the toys in the room while sucking his thumb. His mother's keys had dropped on the floor and he put a key to the lock in his mother's bag.

Cecil had wanted to bring his gollywog, although the mother said: 'He is not really all that interested in it.' Lately he had been sucking his thumb much less.

While we were talking he had taken all the money out of his mother's bag.* All the time his interest in the toys that belong to my room was in abeyance. It was obvious that he had a potential interest in them, but he could not get to them. He picked a button out of his mother's purse and gave it to his mother. The mother said: 'Off my coat', but she did not take it, and this detail illustrates the very subtle something in the mother which constituted a difficulty in her capacity to communicate and to be communicated with at a most primitive level.

The mother reported that Cecil continues to use the parental bed. Waiting for him is a cot in the parents' room. It appears that there is still some difficulty about the parents' going out together because Cecil is liable to wake from 9 o'clock onwards, and then he expects to find them at home.

I wrote again to my colleague on 9 February 1956:

This is to keep you in touch with the progress of Cecil. He now looks like a normal child. He uses many words and communicates freely although without sentences, plays on his own and is not all the time obsessed with putting himself into the infant position in relation to his mother. He would pass for normal but there are residual symptoms. The main trouble is at night, although the nights are very much better than they were. He can now stand the parents' being together and he has no trouble about his father going off to work. On the other hand he needs to sleep in his

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* Compare this with Cecil's behaviour during the consultation on 12 October. The mother's bag had now taken the place of her mouth.

* Compare with earlier behaviour: (*a*) Finger in mother's mouth and (*b*) bag, and with later behaviour: stealing money.

parents' bed with his father turned towards him all the time. This means that the parents can never get together and the mother finds this a terrible frustration. They are willing to put up with this for another few months if assured that the sacrifice is worthwhile.

The technique, which indeed could be called 'spoiling', seems to have had good effect; moreover the mother says that she is gradually coming round to being able to make a more direct contact of give and take, and this is showing in her relation to the next child who, by the way, has eczema but is otherwise normal.

My next contact with the parents was by a letter, this time from the mother (2 July 1956). In this letter the mother discussed the complication of Cecil's aggressive behaviour towards his brother. This aggressiveness had two sides to it, the evidence of healthy development in Cecil, and at the same time the disadvantage from the point of view of the brother. I replied to the parents (4 July 1956):

Your idea of keeping the boy at home seems to have been justified. I don't think I can do very much about the remaining symptoms. It must be very difficult coming to recognize the fact that Cecil has reason to hate his brother. I expect he is fond of him as well and would not like it if he were not there to be hated. You are quite right that he does not have to be made to feel guilty, your job being simply to prevent damage to the brother. There is no reason why he should not know, however, that through his behaviour you get driven into taking the brother's side. It must be very disturbing to you that you still have the boy coming into your bed at night. All I can say is that if you can hang on, that may be the best way of treating the condition, waiting for developments.

The next contact was a visit from the mother (6 February 1957). Cecil was now 3½ years old.

When the mother visited me alone for half an hour she reported an immense change. Not only had Cecil grown, but also he was happier. Nevertheless, she complained that he would not stay in his own bed. She and her husband had not had a single night without

him. They had to make the best of the fact that Cecil is now in his own cot from bedtime till 2 a.m. in order to have a sexual life of their own. 'Cecil feels he has a right to be in his parents' bed and he talks about it.' 'We tell him', she said, 'that we are fed up, and he says: "when I grow bigger".'* He was sleeping next to his father or across the bottom of the bed. The mother said that she loved him very much but she occasionally got exasperated. 'Things are altogether easier with Kenneth.'

The family had now moved house and there were more children in the new neighbourhood than in the old, including a girl of 5. Nevertheless, Cecil had not made any steady friendship. The mother reported that his play capacity was variable; she said: 'He looks forward to children's visits but when the children come he is likely to be impossible.' In the same way his relationship to his brother was unpredictable. 'In short, Cecil has two sides to his nature', she said; 'one is happy and merry and the other is possessive and jealous. In the latter state he tends to play on his own and to imagine that he is a workman or something.'

In dressing up he was choosing to dress rather more as a girl than as a boy, and he evidently envied the girl her role. He continued thumbsucking and had not a regular object of special value, but adopted many teddies and kept them in a pram. He was still very fond of his father. He had a phobia of doctors but this resulted from seeing his brother inoculated and hearing him scream. He would scratch himself all over but without producing a rash. If with his parents he went easily to sleep, but if alone he would lie awake, cheerfully sitting scratching himself till he bled. No genital masturbation had been noticed. He talked a great deal and was very fond of stories. The mother was now looking after the children herself without any maid to help. A new feature was a much more deliberate hitting of the mother when he was angry with her, and the mother felt that she

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* Compare with sophisticated phrase (p. 9).

could now allow herself to get angry in return. He had remorse after hitting her.

After discussion we decided that Cecil must continue to receive this special indulgence at night if the parents could stand it. The strain on the mother was quite great, and I took the trouble to make it clear that I understood this.

After this consultation I wrote the following letter to my colleague (7 February 1957):

I have had a visit from Cecil's mother. Apparently the boy has made a very good recovery as he has nearly emerged from his state of dependence. This regression has been beautifully met by the mother and father, who have allowed themselves to 'spoil' him. The residual symptom is his continued need to be in his parents' bed, which provides a very serious strain on his mother but one that she is willing to take for a further limited period.

There is still, of course, a good deal of evidence of emotional disturbance, especially if the parents attempt to deal with the main symptom in any way other than by allowing it. Much of the day Cecil is happy and playing.

Next came a letter from the mother (9 March 1957) in which she took up the idea of a Nursery School:

When I saw you a few weeks ago about our son Cecil (3½ years) you agreed that it would be good for him to go to a nursery school. Only when I came to arrange for him to go to one of the local nursery schools did I realize that there are long waiting lists everywhere (one is advised to 'book' a child at 6 months). I have tried both private and public ones. At the public one I have been told that if I write to the education authority telling them that Cecil has been difficult, and if I have a letter from you to say he would greatly benefit from going to the nursery school, he would then probably be able to go. I am wondering whether you think it is worth while doing this—or whether this should be left for more deserving cases.

As a result of this letter I wrote to the Education Officer (13 March 1957):

I understand that Mrs X., acting on my advice, has applied for a vacancy for Cecil in a nursery school. I would like to support this application on the grounds that Cecil has been through a period of considerable strain, and I consider that now that he has improved he is in great need of the sort of help that a nursery school can provide.

Cecil first came to see me at 21 months. The boy was seriously disturbed following his recognition that his mother was pregnant.* One of the main symptoms was a sleep difficulty.

I know that there is a waiting list for children for the school and all I wish to do is to refer to Cecil's difficulties and to give my opinion that as soon as he can make use of a nursery school it will be important for him to go there.

In response to this the county education committee gave permission for Cecil's 'exceptional admission to the local nursery school'.

INTERVAL—MARCH 1957 TO OCTOBER 1961

The next contact came in October 1961, when the junior school asked me to see Cecil, now aged 8 years, because he had been stealing. The mother came with Cecil, and I saw her before I saw the boy. Cecil was now just 8 years and his brother was 6, attending the same school.

The mother reported that Cecil had got better but he had never become easy. There had always been phases of difficulty. When he went from the nursery to the junior school he had started stealing, that is to say, when for the first time he met difficulties in his environment, and outside his own home. There continued in Cecil the state of conflict between his wanting to be big and his wanting to be small. There had been some stealing at home; money had been taken from the mother's bag, and also recently there had been stealing from friends. He had also 'found' a watch. At school he was behaving well, apart from the stealing. He had not seemed to be worried about school until a week before the consultation, and then worry had begun to show in the symptom of waking with stomach-ache. 'There is rather a chip on his shoulder', the mother said, 'bound up with a jealousy of his brother'.

* It would not have been prudent to have described in this letter the way in which the boy reacted to the mother's abnormal reaction to the idea of having conceived.

Fig. 1
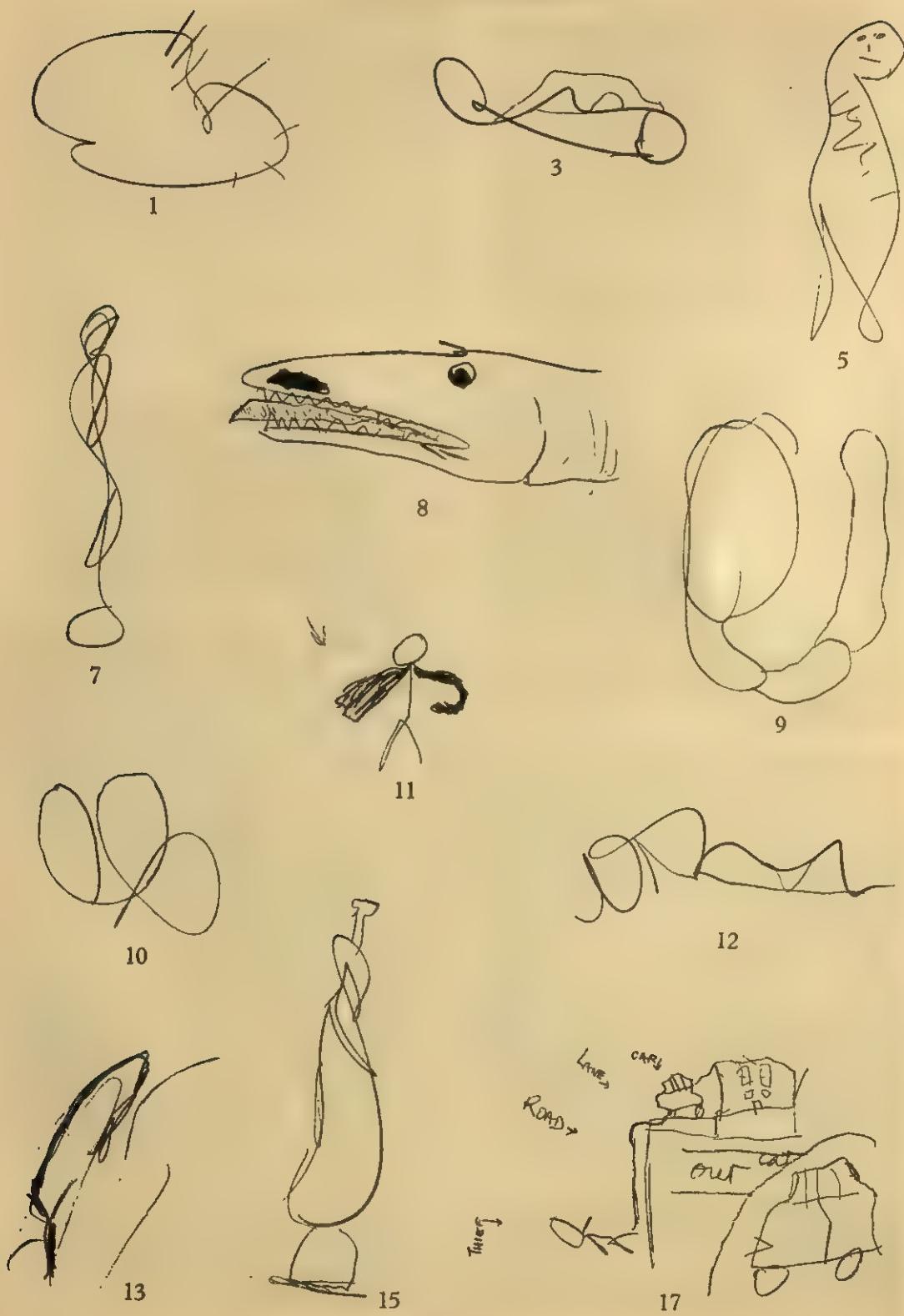
I made a note that the mother was in a depressed state. The father continued to be very patient in his dealings with his family, and the mother continued to be anxious in a general way.

After seeing the mother, I gave Cecil (8 years old) a long personal interview. I put the low child-table between us, and established a contact on the basis of squiggles. (This is a flexible technique for making contact and for communication, and consists of my making a squiggle for the child to see something in, or to turn into something, and then myself turning the child's squiggle into something. It is a thematic aperception test in which the psychiatrist commits himself as the child also commits himself. The main point in this method would be lost if its details should in any way become standardized.)

It was very interesting to me to be in contact with this 8-year-old boy, when I was still clearly remembering my contact with him at 21 months and at 2 years 4 months.

PERSONAL INTERVIEW WITH CECIL
(8 YEARS OLD), OCTOBER 1961

(1) My first squiggle he made into a pond.

(3) Then he made my second into a car. Each of these showed considerable imagination.

(5) He turned mine into a person.

(7) He turned mine into a statue with a sword.

(8) I turned his into a crocodile.

(9) He turned mine into two apples joined together. I made a comment here about the two breasts that they could stand for, joined together on mother's body.

(10) He then did a squiggle which I said was three apples and I said: 'Do you ever dream about apples? He said: 'I dream about what happens the day before and what I have been doing; usually nice.' When I asked about nasty or sad dreams he said he had one sad dream about his friend who broke his arm.

(11) In the dream he was in hospital a long time. He really did break his arm but actually he was only in hospital two hours. He fell on the path by the school. 'He once came to fetch me.'

(12) He turned mine into rocks. This had to do with a holiday in France, and represented cliffs.

(13) He then turned his own squiggle into a G which he said could have to do with garters because he is just going to join the Cubs.

(15) He made into a vase with a flower.

While we were doing the next in which I turned one of his into a flower in a pot he was talking about loneliness and sadness. He knew, he said, what being lonely was. The first few days at school as a day boy he was not sure what to do. The first day he got all muddled up after prayers and so he got late.

I asked him about the advantages of growing up and knowing more about things and he said: '*I don't want to grow up; it's a pity to leave the younger ages.*'*

At this point I weighed in with an interpretation. I referred here to the apples and said they could stand for breasts and for his need to keep in touch with his own infancy and breast-feeding.

Comment. It is a main point in my presentation that this interpretation seemed natural to this boy who had been kept in touch with infancy object relationships through the operation of the regressive tendency which was met more than adequately by the parents' technique of management.

I asked here about father and mother and how he used them when wanting to be held and treated like a baby. He said that he used mother mostly because 'father is always showing me how to do things, how to mow the lawn and everything.' In other words he felt his father to be pushing him on towards growing up. Here was a denial of the importance of the father in his life. He said that he was good at digging. 'I am worst at doing

* It was interesting to get this 8-year-old sophisticated version of his 3-year-old comment: 'when I grow bigger' in relation to the idea of sleeping apart from the parents (p. 6).

things at school which I know already, like sums; doing them for nothing; it's so boring. Exciting new things I can do.'

I then asked him a direct question about stealing, and he told me about a petty theft and also about a dream in which a car is stolen. The dream followed a real incident. In the real incident the car had in it the suit-cases all packed for travelling abroad so the family had to go somewhere nearer home. In this drawing and the boy's association to it there is a mixture of fact and dream. He also told how he had borrowed a friend's pen to use it, which amounted to stealing. Then he said, as if he had come across something im-portant: 'When my brother was two years old he stole 1s. from me'.

Comment. I assume that it was very im-portant to him to express his sense of his brother's usurpation of his rights in this concrete way.

Here the consultation ended, and the boy parted on good terms with me, and quite contented to leave.

In this interview I was able to get a new version of the earlier contacts in which Cecil saw me with his parents present. The sequence was: first, he linked his thumb-sucking with claiming a right to his mother's mouth, then he used his mother's bag and its contents (including money) instead of the mother's mouth. Now he told me about stealing and about being stolen from.

The main detail of this consultation hour relative to the present theme is that the draw-ing of the apples and my interpretation had meaning for him because of the bridge into the past and into the unconscious kept open by this boy's regressive tendencies. Parental management had accepted these tendencies and had met the dependence and thus turned them into a therapeutic procedure. Behind all this was a 'deprivation' related to the mother's reaction to becoming pregnant.

I then wrote the following letter to the head-master of the junior school (20 October 1961):

I saw Cecil, as you probably know, and I also saw him in 1955. The mother has told me about

certain difficulties which have been giving trouble at school, and I have had an opportunity to form an opinion of Cecil and of placing his symptoms in relation to the whole of his development.

In his case, the recent stealing is related to a certain degree of a tendency in the boy to re-capture very early infantile dependence. As you probably know, this sort of tendency can go with the opposite tendency to be very independent. I was able to see when he first came to me in 1955 that Cecil had been adversely affected at the time of his mother's pregnancy and her rather exag-gerated reaction to becoming pregnant. This happened when he was about $1\frac{1}{2}$ years old (October 1954).

I realize that the management of a boy at school must be related to the management of all the other boys and cannot be exactly related to the boy's total development and his difficulties that may date from infancy and early childhood. Nevertheless I let you know this detail because it may be possible for the school to adopt the principle of seeing Cecil through a phase in which these awkward symptoms may be expected. Sometimes it helps masters who are in charge of a child if they can see that there is some sense in symptoms that have no logical meaning in the present-day and in relation to the conscious life of the child.

This produced the following reply:

Thank you for your letter about Cecil, which was very reassuring.

We seem to have got over the difficult phase of stealing without other boys becoming conscious that the disappearance of their belongings had anything to do with Cecil. This has been very largely due to the most helpful co-operation of his parents.

I am glad to be able to report that the boy seems to be settling down very satisfactorily.

In reply to a further inquiry I received a letter from the father (4 December 1961):

Cecil is certainly easier in himself than when my wife last brought him to see you. He still has the same symptoms (that is except for the stealing) but much less so. He sleeps better and does not often complain of stomach-ache. He is not miserable and distressed as he was.

He still has times of being very babyish and easily jealous of his brother but these are inter-spersed by easier more contented times. He seems

very interested in his school and is less anxious about it.

As far as we know he has not stolen since we saw you with him.

When I last spoke to the headmaster, he too seemed to think he was getting on better. I hope he was able to say the same in his letter to you.

Most of the other symptoms remained although lessened in degree and including bouts of babyishness, but there had apparently been no stealing since the interview with me.

Finally I saw the mother and the boy again on 1 February 1962:

First I saw the mother, who reported that there had been no stealing. Cecil had been more positive in his relationship to herself and to others, and more happy, and he was pleased to be coming to see me again. There were still babyish traces which the mother continued to meet as and when they appeared. The brother had now become rather a nuisance and was teasing Cecil. Cecil was standing up to this new complication. The Christmas holiday had gone well. At school Cecil had worked hard and come out top of the form, and he had received a good report. Although he was not stealing he had a certain tendency to make up stories at school. An example: 'I have nine brothers and sisters', etc. etc.

Comment. Some degree of pseudologia fantastica regularly goes with the antisocial tendency and with stealing, and often remains when actual stealing has disappeared.

The mother seemed to me to be less tired and not depressed. Cecil cannot be said yet to have made a definite friend of his own, and this (from the psychiatric angle) is his main residual symptom. Second to this would be his tiredness. The mother knows that she must meet the tiredness and let him go to bed at 5 o'clock if necessary.

Comment. Contained in this tiredness and early going to bed is depression and the residuum of the regressive tendency.

At the end the mother reminded me, or told me for the first time, 'You do understand, doctor, don't you, that with Cecil I was never out-going; not even at the beginning. I realize

this through my relationship with his brother with whom I have been easy from the start, and he has been easy with me.'

Comment. It seemed to me that the mother had come to be able to make this clear statement of the aetiology of Cecil's illness because of the fact that Cecil had now become so much improved, so that she felt less guilty; also because it is she and her husband who have produced this improvement by meeting Cecil's special needs.

After seeing the mother I had an interview with Cecil. He was positive in his relationship to me and very easy. He first chose to draw, and in fact drew a synagogue. We talked about his possibly being an architect. He often draws houses. He then asked me to do a squiggle.

(1) He turned it into a teapot.

(3) This is a crocodile's mouth made by him out of his own squiggle. (There had been a crocodile introduced by me in the first series.)

I asked him whether he remembered the man with the sword in the first series and he said: 'Oh yes', and he became interested in the numbering of the drawings.

(5) He turned my squiggle into a kingfisher.

(7) He made mine into a mermaid.

(8) I made his messy squiggle into something by putting a plate round it and a knife and fork, implying that there was some eating associated with this, and in this I was influenced by his drawing of the crocodile which might eat me, or which might represent one aspect of myself in the professional relationship.

(9) He made mine into a rocket, a jet aeroplane.

(11) He made mine into a witch and broomstick. This had to do with a story that he knew, and the working of spells. Frightening dreams therefore came into the subject-matter of our conversation.

(12) Is like a witch dream. It is his drawing (not based on a squiggle). The witch came to the house and he woke. He said: 'Sleeping is all right, but it is when you wake you forget where you are'. So I said: 'You dream nice

dreams?' and he said: 'Yes' and drew the next.

(13) He was excited drawing a diesel engine with himself driving.

(14) A funny dream has to do with a clown and a circus with children watching. 'I might be a clown' he said.

I asked if he dreamed about school and he said 'No'.

'Have you any friends?'

'Yes, many, but not really a friend of my own.' 'Have you got one that you would like to be friends with?' 'No, not really.'

We then talked about a lot of odd details; his gollywog which is now in the cupboard, etc. He might be a teacher when he is 20, or dig up roads, or be a farmer, or drive diesel engines which he likes very much.

I said: 'Shall we draw any more?' and he said: 'Yes, one more'.

(15) He made my squiggle into a hole with snow in it. 'Yesterday's snow has gone but we played with the snow at Christmas time and made snowballs and a snow man', and somehow or other we came on to discuss the difference between the young and the old and the great age of his grandfather who is 87.

There was no special feature in this contact that would draw my attention to persistence of illness, character disturbance, or personality disorder. I felt that the boy was displaying freedom and a sense of humour, each indicative of health. There was no evidence of a regressive tendency or of a flight from it, in the material of the consultation.

Follow-up (September 1962). 'All well.'

SUMMARY

1. A case is given in detail. All that I know of the case is reported in illustration of the economical aspect of this type of case manage-ment in child psychiatry. The work of the case was done through six interviews spread over a period of six years, and by letter.

2. The boy developed and maintained a capacity to regress to dependence, and the parents met this tendency. In this way the regressions had therapeutic value, and kept open a path to the feelings of infancy.

3. Behind the need for this therapy was a relative deprivation, which was related to the mother's pathological reaction to the fact of her second pregnancy.

4. This tendency to regression in the boy along with the parents' willingness and ability to meet the boy's dependence is closely allied to the periods of 'spoiling' that can be shown to occur in the case of almost any child brought up in a reliable setting.

5. The parents, in this case, wished to play their part, and were eager to carry out the boy's 'treatment' themselves. They did, however, need to be told what they were doing and to be helped from time to time by myself as the psychiatrist who took responsibility throughout.

6. The case was eventually helped forward by a psychotherapeutic interview in which the boy at the age of 8 years used me in respect of his antisocial tendency (stealing). At 8 years, in the drawing game, we reached back to breast contact at a deep level, so that the stealing disappeared from the clinical picture.*

7. There are residual symptoms, including a difficulty in making and keeping a firm friendship. The outcome of the case was favourable, however, in terms of the personal health of the boy in relation to his family and social setting.

* The theory behind this is discussed in 'The antisocial tendency' (1956), *Collected Papers; through Paediatrics to Psycho-Analysis*, by D. W. Winnicott. Tavistock Publications, London, 1958.

Patient, therapist and administrator: clinical and theoretical considerations of a conflictual situation*†

By JOHN L. CAMERON‡

For some time now there has been a considerable output of writings, both sociological and psychiatric, on the vicissitudes of living of the psychiatric patient in the psychiatric institution in which he has been placed for care and treatment, as the result of his difficulties in the outside world. These difficulties are often of quite varied nature, from, on the one hand, activities which may have brought him into conflict with the law, to subjective experiences of discomfort which led him to seek the assistance of the medical profession. Within the institution, the physicians may postulate a variety of causal factors as being responsible for his plight. For example, some may be concerned with the possibility that his inner milieu is maladapted due to deficiency of important neural or hormonal influences which for some reason have become disordered. On the other hand, many may consider that the lack of balance is psychological, due to a disturbance in some form of learning either from a failure of a conditioning process or as a result of early emotional experiences. One way or another, at the outset, the physicians are usually quite clear that they are dealing with an individual whose living is out of order and that he has brought this disorder with him into the new environment. It is a strange phenomenon, then, that this simple concept should sometimes disappear

from sight in the course of the therapeutic venture which then ensues as all parties concerned proceed to seek the health of the patient.

There was a time not so very long ago when the nature of the social interaction in the institutional setting was unquestioned. By this, I do not mean that there were not people who did not try to change the mode of management of psychiatric patients. The work of Esquirol, Pinel, Tuke and Connelly is an obvious contradiction to such a statement. However, in their work, the physician was clearly the physician, the nurse was clearly the nurse, and the patient, the patient. In more recent writings, as our knowledge has increased, these old categories have become fuzzy around the edges. For example, in *Psychiatry*, 1952, **15**, no. 2, we find a paper by Gwenn Tudor (now Mrs Otto Will) entitled 'A socio-psychiatric nursing approach to intervention in a problem of mutual withdrawal on a mental hospital ward'. This title of itself underlines the point of shift which has occurred, for the problem is described as one of mutual withdrawal involving both patient and staff and its interruption involved some soul-searching on the part of the nurse. For example, in her conclusion, she states: 'Thus the labelling of patients as "hopeless", "assaultive", "unresponsive", and "unable to tolerate closeness", serves as a convenient rationalisation for avoiding the patient, and thereby perpetuating the process of mutual withdrawal. We have demonstrated that this deeply ingrained and subtle process, often running its course outside the awareness of the participants, can be systematically observed, evaluated, and interrupted.' What is implicit in this particular paper is a new

criterion for the staff member, namely, that part of their function, part of their skill, one might say, is to question seriously their own part in their relationship with their patients.

A great deal of the basic work in this field was that done by Stanton and Schwartz. In the course of their studies, they threw into question the old concept that the staff of the psychiatric unit were mature and stable individuals. In one of their studies: 'A social, psychological study of incontinence', *Psychiatry*, 1950, 13, 399–416, we find that this particular approach is developed to its utmost. The view which they developed here is that incontinence is a social phenomenon, the resultant of discord in the social scene. This discord occurs specifically between staff members important to the patient. Their answer to this difficulty is to have the staff members in question discuss freely their differing points of view until they reached an agreement about the patient. This agreement they refer to as a consensus, and, with the achievement of a consensus, the social symptom, namely, the patient's incontinence, will disappear.

Dr T. F. Main in the Chairman's Address to the British Psychological Society in 1957, indicates an important point about their work. He states: 'Some of the phenomena that I have described, particularly the terminal social phenomena, are good examples of the social processes to which Stanton and Schwartz have drawn attention. *Their research was not, however, able to include the part played by patients in situations of covert staff disagreement, nor the nature of the patient's wishes.*' He speaks of the problems of the so-called *special* patient with whom his hospital had had no success. When speaking of these patients and talking of their mode of referral to the hospital, he comments: 'The research group later made the half serious conclusion that whenever the correspondence file of a patient weighed more than two pounds the prognosis was grave.' In these voluminous reports, however, Main notes: 'The fact that some of these patients had been in mental hospitals and that several had a history of

self-destructive acts in the past, was mentioned—if at all—not as of warning significance, but as an example of former wholly unsuitable handling. In two cases, there was a clear statement, that if the patient was not admitted soon, she would have to go to a mental hospital, the implication being that this disastrous step would be all our fault.'

It is the intention of this paper to emphasize the factor not studied by Stanton and Schwarz, namely the part 'played by the patient in the situations of covert staff disagreement' and to attempt to evaluate the type of patient who becomes so embroiled. The clinical data are derived from direct observations made by administrator and therapist in such situations.

CLINICAL EXAMPLES

At the time of the clinical incidents which are going to be described, they of course occurred in a social situation where the phenomena so well described by Stanton and Schwartz constantly exerted their influence on the people involved. However, the discussion has been arbitrarily limited to the therapist, administrator and patient by using the administrator as the figure who could or could not alter the patient's living arrangement. The situation, then, was as follows. The therapist saw the patient for four psychotherapeutic hours a week, and the administrator was responsible for such things as physical health, diet, ward management, privilege status, including freedom to go home for week-ends or to live outside the hospital as an outpatient.

The first clinical illustration is almost a caricature of the type of situation under study. The patient was a colourful and rather good-looking woman in her early thirties, who came to the hospital predominantly because of a dangerous addiction to doctors. She was unsurpassed in her ability to undergo surgical procedures, varying from dilatation of the cervix and curettement of the uterus to the implantation of some spongy substance designed to make her breasts more prominent.

From a variety of medical sources, she had obtained a truly formidable cross-section of the pharmacopaea which she persistently used to the extent that she was incapacitated. Typically a definitively diagnosed subacromial bursitis was under treatment by several different physicians, none of whom knew of the other's existence in the case until two of them accidentally met at a medical meeting. On her first arrival in the hospital, the patient very rapidly improved with the removal of her access to various medications, and she blossomed as she talked with her therapist. In about five or six weeks, however, she became extraordinarily critical of her administrator. Nothing in the management of her living was correct. This criticism was particularly directed, of course, to her physico-medical care, but everything else in the hospital was similarly attacked. Following an unsuccessful daily series of discussions: between patient and administrator, a three-way meeting of patient, therapist and administrator was held in the hope of resolving the difficulty somewhat, but the meeting was not satisfactory and the therapist was as vociferous in his complaints as was the patient. Following this came a period when the administrator was bombarded with complaints by both patient and therapist. The matter came up for constant discussion at the administrators' conferences without benefit and the administrator's solution, finally, was one reminiscent of Gwenn Tudor's paper, for he withdrew from the case and the patient was transferred to another administrator's care. The new administrator had already heard all he wanted to hear about the situation and declined to take any active part. Within three months the patient left treatment.

The question, of course, is, what was wrong? The administrator could have been a lot rougher and a good deal more firm in his dealings with the patient, or he might have been able to provide a more comfortable environment for her. From the point of view of the therapist, why did he have to get involved to such a total degree in bettering the patient's environment, rather than getting on with the business of psychotherapy?

In the hope of shedding some light on this, let us take two somewhat similar clinical situations, the cases of Miss A and Mrs B. Both of these two ladies were brought into the hospital with well-established illnesses of paranoid type; both had a long history of previous hospitalizations; they were both rather formal people, with somewhat intellectual interests. Certainly the unmarried lady, who was older, had been ill longer and her prognosis might have been viewed as worse on that account. Certainly, the vicissitudes of their hospital life and its eventual outcome could not have been more different. The events with Miss A were similar to those with the first patient described, but were even more fierce in their intensity. The therapist not only scolded the administrator, but fussed, also, at the charge nurse and the aides on the ward. She, caught in the middle of this, was upset, not merely by the attack on her personal skill, but by a conflict of loyalty as she found herself wondering about the skill and capacity of the administrator, who had, until then, been a close friend and colleague. The therapist's supervisor on one occasion stormed into the administrator's office, raging that he did not see how therapy could continue in such an adverse environment. Both administrator and charge nurse, discussing the case later, complained of the feeling of utter aridity and futility which they had experienced during this period. Both had been angry and both had been on the point of resigning from the hospital and, in fact, would have done so, had the patient not been transferred to another unit.

The course with Mrs B, on the other hand, was almost the exact opposite. Very rapidly her delusional system broke down. Steadily she made progress, becoming first an outpatient of the hospital and finally completing her analytic therapy privately with the same therapist. Although she quarrelled at times with the administrator and with the staff, these disagreements were resolved through

discussion by the parties involved. The therapist would have no part in any of it. However, he often talked to the administrator of his tremendous personal despair during the work and said, subsequently, that he had often felt that the administrator was being reassuring to the point of untruthfulness when the latter expressed his admiration for the therapy. He stated that there had been long periods when he and the patient had felt that they were walking together through a vast, empty desert without limits or horizon.

What is noteworthy in this particular series is the transposition of feelings which can be seen. In the one, both therapist and patient complained persistently and angrily of the ineffective, damaging and unimaginative environment created by the administrator and his staff. In the other, in contrast, the patient and therapist together experienced an empty and arid despair, through which they managed to live to a successful outcome. What, one may ask, is the difference? And how does it come about?

From the administrator's point of view the two unsuccessful ventures were characterized by a particular type of behaviour on his part, which did not appear in the successful situation. In both of them he became involved in long discussions with the patient in which he endeavoured to 'understand' the patient and to talk in a manner which was helpful and therapeutic.

THE ESSENTIAL THERAPEUTIC QUESTION

The essential therapeutic question is the one which has already been mentioned in the introduction, namely, what is the patient's pathology? What does it have to do with the disasters of their living and in the cases in question, what did it have to do with this terrible event, namely, a failure of psychiatric therapy for a serious mental disorder? It is always easiest when trying to evaluate something to approach it in its simplest form. The simplest form in which one can observe the manifestation of something in one person which tends to influence others is when it tends to influence only one person, in this case, of course, the therapist in the therapeutic situation.

The patient, Miss C, an unmarried lady in her middle thirties, had come into therapy privately for a variety of physical, social and psychological dissatisfactions. If one were to categorize her, she would perhaps best be viewed as a moral masochist. Everything which she reported tended to indicate the unsatisfactory nature of her every experience. However, she was unable to appreciate the fact that the expression of an identical complaint eighteen months after the start of therapy might possibly be an expression of dissatisfaction with her therapist, who had so singularly failed to influence her discomfort. In the course of describing her family, being a somewhat sophisticated person, she spoke of the paranoid integration which existed between her parents, of her antagonism towards both of them, of her father's whining inadequacy, and her mother's persistent martyrdom. In all of this, there was nothing which was positive and one day, finally, the therapist commented: 'It would sound from what you are saying that the skeleton in the family cupboard was love.' Shortly afterwards, the patient reported that she had made a visit home for a week-end. She and her mother and father had spent the greater part of the Sunday afternoon discussing the implications for all of them of the therapist's wise remark that 'love was the skeleton in their family cupboard'. The parents, rather serious-minded folk, who were concerned about their daughter's welfare, did not flinch from the discussion, painful though it was. The father indicated that he could see what the therapist meant, in a dim sort of way. The mother, however, had been more overwhelmed by the possibility that some lack of demonstrativeness on her part had contributed so much to her daughter's illness. The patient reported all of this with some pride, for it appeared that what the therapist had said might be of some value in making

her family more reflective, although she herself remained so unaffected by his efforts. The important point in all of this is the patient's complete failure to grasp the fact that the therapist's remarks had been directed toward her view of the family as reported to him by her and were in no way representative of his opinions of the family itself, whom, of course, he had never even met. In fact, then, when this patient expressed something, this was not an opinion, not a thought or idea which she herself had and which consequently might differ from other people's. No, on the contrary, it was a statement of some kind of actuality; some kind of fact as hard and immutable for her as is the hard, concrete external Marxist reality for the Marxist thinker. Accordingly, for her, the therapist's comments were a manifestation of his perceptiveness in noticing something about the world of her childhood experience which she had always known, but had never expressed so succinctly. Sophisticated though she was in psychiatric theory, the possibility that she might have avoided noticing any manifestation of love and affection in her family for private reasons of her own, such as envy of the parental relationship, or repressed all such memories in the service of maintaining a martyred position, was quite beyond her. What she did with it instead was to take it home and hold a group meeting at which a consensus was reached which led to some painful soul-scraping for the parents and confirmation for the patient of her original tragic and self-hurtful observation that all members of her family, herself included, were unable to manifest love.

To illustrate this point further, here is an example from the work with the same lady. She came in at the end of one week, worried and quite anxious. It transpired that her mother was going to visit her during the next week. She found herself seriously questioning her motivation in therapy because she was considering taking an hour off from treatment the following Friday, so that she could drive her mother home to a city several hundred miles away. She was not able to elaborate further on her discomfort. The next Monday, however, she described an extraordinarily distressing and sleepless week-end. She demanded of her therapist that he tell her whether or not she could take the Friday hour off. Attempts at exploring her motivation of this demand led to a furious and anguished outburst. It eventually became clear that she felt she was involved in something quite crazy. It appeared that she was much preoccupied with whether or not the therapist would charge her for that hour if she missed it. What did not make sense to her was as follows. 'I know that you can be stubborn in your own way. You have never, however, been unpleasant about fees. I know there is no issue between us in this matter. There really is something here that feels quite crazy.' As she talked throughout the rest of the hour, it became clear that she felt that she was a manipulator and that her behaviour would in some way cause the therapist to behave like a bastard. On being asked what she felt about that, she replied: 'If I turn you into a bastard like that, there would be no point in continuing in treatment. I would just have to quit, rush out of your office as soon as I discovered it and never come back.' In this example, one can see more clearly that the patient's thoughts are the totality of her world. Her opinions, her views, are undistorted reflections of an immutable reality. Should she see her therapist as an absolute bastard, this would be all that there was to him. The possibility that she might so see him in a moment of transitory anger and then later change her mind in another mood was quite beyond her. What she thought at any point existed forever and should what she thought be unpleasant, then she could only flee from it, not as an inner concept, but as an outer reality.

The patient who has been described, is, of course, a functioning citizen, operating moderately successfully in the outside world. When the author remembered, however, the lesson from her, he could see more clearly

something of the characteristics of the patients who were involved in the situations with therapist and administrator which ended so unsatisfactorily for everyone concerned. However, another clinical example would be of some value at this point. Miss D came to the hospital as a result of a series of experiences which had interrupted her psychotherapy with an analyst in another city. She emphasized at the time of her admission to the hospital, that her, to use her own words, 'psychotic break' had been the result of her family's reaction to some separation anxiety which she had experienced during a brief absence of her therapist. Her family were insensitive, manipulative, domineering and controlling. They had always been opposed to the therapist and had seized the excuse to rush into the situation, acting in the secretive, power-dominated way which they always used in their transactions with her. They had compounded the situation by bringing other physicians into the picture, at which point she, overwhelmed by a confused and threatening environment, had reacted with such intense anxiety that she had had a defensive psychotic reaction. In all of this, her former therapist remained a figure of incredible goodness, wise, well-educated, sophisticated, philosophically well-read and yet withal, very sensitive and tender. Within a few weeks, Miss D settled down in the hospital. She quickly found out that her new therapist was interested in philosophy and it was soon clear that she felt she had a special relationship with him, too, as she had studied the subject in a university. Before long, a familiar theme began. The hospital was an unpleasant place. The staff were insensitive to the needs of an individual of her kind. The other patients were different from her and 'Do you think that I am the same as them, doctor?' The administrator was soon depicted as an anxious, inexperienced, defensive person whose failure of personal insight had not yet been corrected through personal analysis. Since this was the case, would not the therapist talk with him? It seemed to her that

this was the only solution to the impasse, because she would not be listened to by the administrator, but the therapist, with his experience, seniority and personal insight, could surely explain her to the administrator in a way that would enable that physician to act in a more therapeutic manner. One can see here a parallel with the thinking of Miss C, the private patient already mentioned, for, once again, what the patient describes is a view which she is sure her therapist shares with her. It is, once again, in her eyes, a statement of a harsh fact of reality which has to be faced. What she thinks *is*, and she cannot conceive of the possibility that his view of the administrator might be quite different. This particular lady made it quite clear that it was all a matter of the degree of sensitivity that made the difference. Those who did not agree with her lacked an ability to appreciate the environment. If the other person were not actually in the situation with her, then they had to be made to understand that what she needed was trust and by trust she meant an unqualified acceptance of her view of the world. Comments from her therapist about her account were frequently taken as agreement. For example, following one of her diatribes against the administrator, a comment such as, 'It sounds as though you feel you are not being properly understood' was taken as agreement with her view and the administrator was promptly told by her that her therapist agreed with her that he, the administrator, was mishandling her. Comments from the therapist about her mistake provoked anger and anxiety from the patient. However, a policy of constantly paying attention to these misinterpretations of hers was found to be more effective than to interpret her attacks on the hospital or the administrator as displacements of some doubts or questions she might have had about therapy. Following some outbursts of anger, the patient finally made it clear that she did have some very serious reservations about therapy. She was uneasy that her attachment to her new therapist would be disloyal to the original

therapist. It has been her half-formulated and unclear intent to utilize her complaints about the hospital as an excuse to leave, so that she could resume her treatment with her original therapist. Later discussions made clear that to discover that her original therapist might have feet of clay was as terrifying to her as was the possibility for the private patient that her therapist was a bastard. In fact, to revise the inner image of her old therapist meant to the patient that she would destroy her (the therapist was a lady). Similarly, in dealing with the current therapist, she constantly attempted never to provoke any situation in which he might seem to her unfriendly, hostile or angry, because if such an incident occurred, then her opinion of him would be an actuality which could only be handled by precipitate flight.

DISCUSSION

It is the contention of this paper that the most important pathology in the situations described lies in the patient. It is not the author's intention to disagree in any way with the following statement by Main: 'Our findings agree with those of Stanton and Schwartz that certain patients, by having unusual, but not generally accepted, needs cause splits in attitudes of the staff, and that these splits, if covert and unresolved, cause the greatest distress to the patients who could be described as "torn apart" by them. These two writers warn against easy assumptions that the patient is trying to drive a wedge between staff members, and they point out that the patient's distress can be dramatically resolved if the disagreeing staffs can meet, disclose and discuss their hidden disagreements and reach genuine consensus about how the patient could be handled in any particular matter. We found, however, that the staff splits, while precipitated by disagreements over present events, occurred along lines of feeling and allegiances that had existed prior to the patient coming into hospital.' However, it is the intention of the paper to discuss something of the nature of the patient's pathology and to

suggest a method of intervention based upon the views developed.

An important feature which can be observed in the thinking of the patients described in this brief account was their tendency to regard the content of their thought as a reflection, purely and directly, of outer reality. Whatever they thought up, regardless of their affective tone at the time, was forever fixed and unchanging. This type of phenomenon is commonplace in itself, being a reflexion of omnipotent thought, and, of course, of a narcissistic style of mentation. Much has been written on the subject. There is even the footnote in the *Interpretation of Dreams* by Freud which refers to the fact that schizophrenic patients behave as though thoughts and ideas were in fact the objects which they represent. On the whole it is regarded as a manifestation of a profound and severe degree of illness. Of the writers who have referred to this subject, Ferenczi and Fenichel wrote earliest and in the greatest profusion. Ferenczi, in his paper, 'Stages in the development of the sense of reality', placed omnipotence as a feature of the early oral phase. Fenichel states as follows: 'The separation of ego and objectual world is no sudden process; it takes place slowly and gradually. A longing for the original objectual state probably always remains ("oceanic feeling").' One can see here that there is an implication that at least a longing for a return to the Nirvana-like state in which omnipotence ruled mentation, is at least a potential in every psychic structure. Fenichel states, in fact: 'A large part of certain narcissistic feelings of well-being of later times, has the characteristic content of reunion with an almighty being of the external world.' Further, the same author comments: 'From these insights into primitive omnipotence, we may derive, as Rado has clearly shown, an understanding of a need which is very important in the psychology of human beings in general. The memory of past stages of omnipotence (and of their having always been interrupted by unpleasurable states of hunger, and restored by satiation) persists in

the form of an eternal longing to recover them.' In the face of such a clear warning regarding the ubiquitous nature of such a longing among human beings in general, the possibility that it should exist among people with character disorders is not surprising.

Both Ferenczi (1913) and Fenichel (1937), among others, have indicated their observation that the condition is frankly manifested among many people with both neuroses and character disorders. They particularly stress its appearance in the obsessional neurosis in the form of the well-known magical thinking of that state. In the cases under consideration, the omnipotence is an important feature of the thinking, but it operates in a subtle and masked way. It is, in fact, not usually the case that the person in the immediate situation shows other severe manifestations of mental disorder. For example, one of the patients mentioned in the previous section was carrying out a difficult and complicated task to earn her living in a manner which was above the average standard in her profession. Miss D gave one at times serious cause to question whether or not she did need to be in a mental hospital, for her behaviour and manners in a social sense were extremely good. This subtlety and the masked nature of the omnipotent thought, is the first real snare which I would like to underline, for it was extraordinarily difficult to appreciate that her view of the administrator was the result of rigid, concrete and omnipotent thinking, a narcissistic manifestation, not correctible by external experience, rather than the result of an unfortunate series of experiences at the hands of the foolish, or perhaps even sadistically inclined, administrator.

However, although, even in its raw form, this omnipotence is difficult to isolate, the difficulty is in fact compounded by the intact nature of the other secondary processes of mentation. Such patients have a great ability to defend themselves, in common with the rest of the human race, and to defend the position which they adopt they employ a highly developed ability to think causally and

so prove their contention, whatever it may be. This feature of their personality manifests itself as argumentativeness and their persuasive capacity is extremely high. One might regard them as having an inflated will in the old Thomist sense. A not uncommon, final line of argument which the author encountered is: 'But you weren't there, so you don't know. You must trust me. If there is no trust, there is nothing.' This statement, of course, flies in face of the simple fact that they are talking to a psychiatrist in an expensive hospital whose expensive fees they would not dream of paying if they themselves were able to trust themselves. They insist that the psychiatrist must trust their judgement when they have already demonstrated that that judgement is quite inadequate to maintain them in the community.

Another feature, often as appealing to the therapist as their logical ability, is their perceptiveness. I know of no group of patients whom I have encountered who are as quick to observe fluctuations of physical and mental welfare in the therapist as are citizens of this type. This perceptiveness, however, if one listens carefully to the patient's expression of it, is marred by the same rigidity of thought which we have been discussing, so they are not truly perceptive or sensitive in an artistic sense, but merely extremely acute to sensory impression. This sensory ability is utilized to reaffirm a pre-determined narcissistic conclusion. For example, Miss C was quite clearly aware of her mother's distress in the course of their Sunday afternoon's conversation, but she attributed this to the experiencing of a real guilt felt by the mother on being faced with her actual ill-doing in failing to manifest love and affection, rather than to parental distress at being subject to such an accusation by her daughter, and, as far as she knew, by her daughter's doctor. The patient's view of her mother's distress, of course, is only one alternative in a very considerable series, but for the patient the conclusion was already narcissistically determined. When faced with such an acuteness of observation, it is often quite difficult for the therapist to

appreciate that what the patient does with the observations is so pathological. For these patients can describe very accurately everyone except themselves.

Fenichel laid stress on both the two points made above as follows:

Single ego functions may prolong, or reassume, the possession of certain characteristics belonging to the primitive phases; in this sense we may designate 'eidetic' types as perceptual fixations. Or the form of thinking may retain more of its magical character than it does in normal persons; this is the case, for instance, in every obsessional neurosis where a very precociously and strongly developed intellect is in sharp contrast to the belief in omnipotence and talion held by the unconscious parts of the ego. (The defensive work of obsessional neurosis is a far more active achievement of the ego than is that of hysteria. It is based, as Freud has said, on the fact that the development of the ego has 'hurried ahead' of the development of the libido; but the early demands made on the ego at a time when it still has some of its archaic characteristics evidently gives occasion for a fixation on precisely this stage, despite the precocious flowering of the intellect.) Or else, again, the manner of dealing with objects shows primitive characteristics; there are fixations at pre-stages of love, at incorporative aims, at the regulation of self-regard as it obtains in small children. These types especially are often designated as 'oral', and rightly, in so far as their ego has retained a characteristic which it had at the time of the oral stage of libido organization. One must note, however, that there may be a discrepancy between ego development and instinctual development; while the 'oral' type of regulation of self-regard persists, the oral zone need not likewise remain libidinally dominant.

A further complication mentioned in the clinical data is the desire of these patients to avoid conflict and disagreement. Employing their very considerable ability to observe, they try very hard, and usually successfully, to pick out areas of their experience and interest which they have in common with their therapist. This urge to avoid conflict can be easily seen once one is alerted to it. It is, of course, an attempt to avoid seeing the other as something totally destructive; but its result outside a therapeutic situation can only too easily be the formation of an in-group of 'friends' who are sensitive, wise, etc., etc., while everyone else with whom one is in contact is relegated to a status outside the pale where everyone is insensitive, unwise, if not actually bad and destructive.

The ideal situation in which to observe this type of phenomenon is in the relationship between psychotherapist and patient. Similarly, close attention to the manifestations and origins of such a thought disorder and intervention to correct it in that situation is, in the author's opinion, the best technique which can be medically employed. It is, of course, a manifestation of a character disorder which, in itself, cannot be placed in any clinical category, as it occurs in a variety of clinical entities. In this situation the author realized how easy it was to accept a highly destructive view of the patient's environment rather than to appreciate that this highly destructive view of the environment was the patient's unspoken presenting complaint. This difficulty leads to the type of action which results in the therapeutic debacles already described. The reasons for the staff so acting may not be merely the results of the patient's persuasiveness. These perceptive patients may well pick up on the hospital grapevine and confirm by their own observations some transient interpersonal antagonism in the therapist which they then fan into fury. They do not do this, as Main points out, in order to cause schisms in the staff, but because of their desire to find yet another point of agreement with their nice doctor and to indicate that even though they may be merely patients, they can give support and understanding to their therapist, administrator, or nurse.

The therapist of one patient summed up this danger very well when he spoke as follows, referring to the activities of himself, the author as administrator, and the charge nurse, when he said, 'I am this patient's therapist, or perhaps I should say, one of her *three* therapists'. In retrospect, the author

would say that this, in fact, was the area of administrative error which occurred in each of the debacles described earlier. In addition, however, each of those patients had two or three administrators and in at least one of them, three charge nurses as well.

CONCLUSION

It is the author's opinion, then, that the staff members working with these interesting but difficult people should not be especially 'careful' in dealing with them. They should not try to be especially astute or sensitive, though they will be under great pressure to respond to the patient's omnipotent demands for just such a demonstration of omnipotence. In the course of the psychotherapeutic work, one will have to anticipate a re-enactment of the tremendous disappointment, disillusionment, or some such hurt, basically at the root of the patient's difficulty and which is referred to by the early psychoanalytic writers as a narcissistic wound.

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Formal Discussion

BY HAROLD F. SEARLES[*]

In this valuable paper, Dr Cameron helps us to understand a variety of patients who, while representing a wide range of the usual diagnostic categories, as a group cause some of the greatest difficulty to the staff of any hospital, and who are, as he has carefully portrayed here, like one another in possessing a thought-disorder which is oftentimes particularly difficult to cope with by reason of the subtlety of its operation in a person who is otherwise not grossly psychotic.

He in no way minimizes the value of Stanton & Schwartz's classic contributions to the treatment of these difficult individuals when he emphasizes the central role, in these tangled patient–therapist–administrator situations, of the patient's pathology, namely the patient's conviction that what he thinks *is*, or, in other words, his inability to differentiate between the realm of his own thought on the one hand, and external reality on the other hand.

Dr Cameron helps us to see how specifically supportive of the patient's pathology it would be for us, as a hospital staff, to assume a primary blame for the patient's tangled current life situation, when he says: 'In this situation the author realized how easy it was to accept a highly destructive view of the patient's environment rather than to appreciate that this highly destructive view of the patient's environment was the patient's unspoken presenting complaint.'

This same sentence of his serves, for me at least, to point up one of the great advantages of the patient's having two different doctors, a therapist and an administrator. This system, which most hospitals do not use and which some of our own staff do not find very congenial, does at least facilitate the resolution of

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the kind of central pathology with which this paper deals—that is, the patient's need to become *able to differentiate*, not only basically between himself and the outer world, but between the more symbolic and the more concrete realms of thought, which in him are fused. If, to use a simple example, both therapeutic and administrative functions were the responsibility of a single physician, that physician would find it especially hard to discern, in a patient's insistent demands to 'move out', a subtle symbolic meaning which the patient is unable to formulate as such in his own mind, namely a plea for help in 'moving out' of his shell, out of his isolation *vis-à-vis* his fellow men. In other words, I think that the kind of nice discernment of a subtle thought-disorder such as Dr Cameron has described for us is facilitated for the therapist who is comparatively free to look and listen for the so important symbolic undertone, knowing that a fellow physician has the prime responsibility for meeting the so-called 'real' aspects of the patient's current living.

I did wonder at Dr Cameron's terming this subtle omnipotent thought 'not correctible by external experience', for this would seem to imply that it is incurable, which we know he does not mean. I presume that he means to indicate here that the thought-disorder is not resolvable by, say, administrative management alone, in which case I do not feel impelled to argue with him. But administrative management can make specific contributions, I believe, to the resolution of even so 'deeply intrapsychic' a problem as this, if I may use that term. I remember, for example, a young schizophrenic man who was described by his therapist, at a staff presentation, as suffering from a pervasive fluidity of his ego-boundaries, and from my therapeutic sessions on his ward, with another patient, I knew this young man to be a person who, by reason of a bullying demeanour, faced down all attempts to stop his incessant 'inspection trips'—that is, his making periodic and frequent trips through all his fellow patients' rooms, without

knocking. Administrative management which insisted upon the privacy of his fellow patients' living areas might well have helped this man to realize where his own ego-boundaries lay.

But, as a therapist, I am quite ready to grant that the main job, here, is to be done in the relationship between therapist and patient. Beyond the valuable policy of constantly paying attention to the patient's misinterpretations, which Dr Cameron mentions as his view of what the therapist needs to do in this regard, there is something more basic which happens in the therapeutic relationship, in my experience, in the long run.

Briefly, the concepts which I apply in interpreting such data as we have heard, here, are as follows. In normal maturation, a state of comparative freedom from ambivalence holds sway in the symbiotic relationship, the subjective oneness, between the mother and her very young infant. Then, after a number of months, by reason of the increasing complexity, and therefore less ready satiability, of the infant's needs, the individuation process makes itself felt with increasing intensity, to the accompaniment of increasingly mixed feelings in both mother and child, including mutual disillusionment with one another. If the mother is not unduly ambivalent for neurotic or psychotic reasons, the young child is able to manage this transition from original symbiosis with an adored mother, through this period of ambivalence and disillusionment, to the achievement of personal individuality—to acceptance, that is, that he and his mother are separate individuals. The individual who later becomes schizophrenic has not been able, because of severe, repressed ambivalence in his mother, to make this transition in early childhood; he clings to symbiotic relatedness as a defence, and in adulthood finally becomes overtly psychotic in a context, typically, of overwhelming disillusionment, such that it is impossible for him to maintain, any longer, his relatedness to a formerly-adored symbiotic partner.

In this therapy, then, he seeks to preserve

an atmosphere of adoration between himself and his therapist, while directing his scorn and other negative feelings toward other persons such as the administrator. But in order for him to become what one might call 'successfully disillusioned', his feelings of scorn and adoration must be brought together, as directed toward a single person, the therapist (as a representative of the early mother). Over the course of some years, if therapy is eventually successful, patient and therapist are able to integrate, in their relationship, increasingly intense feelings of scorn, disillusionment, and genuine adoration toward one another, as a result of this transference-reliving of the patient's warping early experiences. Finally they make contact with the pre-ambivalent, genuinely loving increments of symbiotic relatedness such as were present in at least some degree between the patient as a very young child or infant, and his mother.

And here we see—and this is my main point—that the adult patient's equating of his thought-picture of outer reality with outer reality itself is, far from being an indication of basic destructiveness, the birthright of the normal infant, a birthright which he in his infancy had been traumatically denied. Winnicott (1945, 1948), Milner (1952), and Rycroft (1955) have each described the importance, for the infant's establishment of what they call a creative relation to the world, of his having the freedom to experience outer reality, at first, as something which he himself has created.

Milner describes her therapy of an 11-year-old boy who had found outer reality mechanized and soulless by reason of its unacceptingness of his own spontaneous creation, a difficulty she found traceable to a premature loss of belief in a self-created outer reality. She describes how she helped this boy to achieve a healthy relatedness to reality through her acceptance of his treating her as being part of himself—as being his own malleable, pliable, 'lovely stuff', his chemicals, which he

had created. Winnicott, out of his extensive experiences with paediatrics as well as with psychoanalysis, advances the following hypothesis as to how the healthy mother helps her baby toward an acceptance of external reality, through helping him to experience this reality not as something alien to himself, but as something self-created:

...by fitting in with the infant's impulse the mother allows the [nursing] baby the *illusion* that what is there is the thing created by the baby; as a result there is not only the physical experience of instinctual satisfaction, but also an emotional union, and the beginning of a belief in reality as something about which one can have illusions. ... In the course of breast feeding a mother may repeat this performance a thousand times. She may so successfully give her child the capacity for illusion that she has no difficulty in her next task, gradual disillusioning, this being the word for weaning in the primitive setting which is my interest in this paper (1948).

...at the start a simple *contact* with external or shared reality has to be made, by the infant's hallucinating and the world's presenting, with moments of illusion for the infant in which the two are taken by him to be identical, which they never in fact are.

For this illusion to be produced in the baby's mind a human being has to be taking the trouble all the time to bring the world to the baby in understandable form, and in a limited way, suitable to the baby's needs. . . (1945).

Just how the therapist provides such help to the patient, at a symbolic level, in what I think of as the 'therapeutic symbiosis' phase in the transference-evolution, is a matter which deserves our careful study.

I have been grateful for this opportunity to comment upon this thought-provoking paper of Dr Cameron's, for this comes from a man who has earned the greatest respect from his colleagues for his skilful work in the fields of both psychotherapy and administration. My comments have been intended primarily as extensions of some of the points which he has raised here.

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Personality characteristics in males conducive to lung cancer

By DAVID M. KISSEN*

The concept that psychological factors might play a part in the aetiology of cancer is not a new one. Galen (A.D. 131–201) is reported by Mettler & Mettler (1956) to have said that cancer was much more frequent in 'melancholic' than in 'sanguine' women. Two recent reviews, by Kowal (1955) and by LeShan (1959), show that from the eighteenth century onwards the concept has been given attention by physicians and surgeons though the literature is not voluminous. In the past decade or so, there have been many studies using the techniques of modern psychiatry and clinical psychology. An assessment of the literature on personality and cancer contained in a leader in the *British Medical Journal* (1956) expressed some scepticism of the quality of the research reported. Similar criticism has been made by Perrin & Pierce (1959) in a recent review of twentieth-century literature. In both criticisms the need for adequate controlled research in this area was emphasized.

I have not come across any reports dealing with psychological factors in lung cancer *per se*. During the past few years I have been carrying out what might be termed psycho-social studies in lung-cancer patients. By the time I had seen about 150 lung-cancer patients and a corresponding number of controls, some of the clinical material elicited suggested certain hypotheses. These include the following—that, in contrast to the non-cancer patients studied, lung cancer patients (1) have a significantly diminished outlet for emotional discharge, (2) tend to bottle up or conceal their emotional difficulties.

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To test these hypotheses, the original studies were extended to include (1) a personality inventory—the Maudsley Personality Inventory (M.P.I.), and (2) a clinical questionnaire designed to elicit pertinent factual clinical data at a personal interview. A report of the related M.P.I. study has been prepared separately (Kissen & Eysenck, 1962). This present paper describes that part of the investigation using the clinical questionnaire and discusses the relationship and possible meaning of the personality features reported in both studies.

MATERIAL AND METHOD

Patients are studied at three chest units to which they are admitted for diagnosis and treatment. Two of these units are surgical and one medical. The units admit not only patients in whom lung cancer may be suspected but also patients with a variety of other suspected thoracic disorders.

In most instances, at the time the patient is interviewed by me, the true nature of the diagnosis has not yet been confirmed by the physician or surgeon in charge, especially where cancer is a possibility. Of course, some patients on admission may be made aware of a diagnosis such as pneumonia or bronchitis or other non-malignant condition, but a proportion of these patients may subsequently prove to have neoplasm. Patients with pulmonary tuberculosis are usually admitted to special tuberculosis wards in these units. Some tuberculosis patients, originally admitted because of suspicion of a non-tuberculous condition, are, however, included in the series. In no case is any diagnosis known to me at the time of the interview.

All patients aged 25 and over admitted to these units, whatever the suspected diagnosis, are seen by me except where this is not possible because of my absence on holiday or for other reasons. There is no intentional selection. Patients are seen in privacy, mostly during the week following their admission. They are never seen after surgical operation.

The total number of patients included in this report is 335, of whom 161 had a diagnosis of primary lung cancer. In the remainder a diagnosis of cancer of any organ was excluded. These serve as controls and include a variety of conditions, among them bronchitis, emphysema, pneumonia, bronchiectasis, pneumoconiosis, lung abscess, asthma, pulmonary tuberculosis, simple growths, heart conditions, etc., and some with no disease. No patient refused to co-operate. All patients are males. Females are also being studied but their numbers are too small, so far, for assessment.

A previous sample of these patients shows no suggestive differences in social class between those diagnosed as suffering from lung cancer and those not having cancer (Kissen, 1962). Nor are there any suggestive differences between the two groups in the nature of the occupations.

Clinical Questionnaire

A. *Childhood behaviour disorders*

As one measure of capacity for emotional discharge it was decided to use the incidence of behaviour disorders in childhood as elicited from the patient. One reason for employing this measure was to try to corroborate and give a meaning to whatever findings emerged from the other measure of capacity for emotional discharge that I had decided to use —the M.P.I. Another reason was that it appeared less empirical than the M.P.I. Childhood behaviour disorders such as (i) bed wetting, (ii) fears, phobias, anxieties and sleep disturbances, (iii) stammering, (iv) trouble with authority because of truancy from school, or trouble with the police, (v)

temper tantrums, are all early expressions of emotional difficulties and their incidence may be more readily *seen* to be related to capacity for emotional discharge. Questions relating to the occurrence of those five childhood behaviour disorders were therefore asked. It was not intended to try to cover all childhood behaviour disorders. Those used were selected arbitrarily as representative disorders which might shed some light on the hypothesis under review.

Patients were not asked the precise ages in childhood at which these disorders occurred. In the case of bed wetting, it was felt that if the patient could remember that he was a bed wetter, it was unlikely to be the normal bed wetting of early childhood that he recalled. The chances of any such error occurring are just as great (or as small) in the lung-cancer group as in the non-cancer group.

It should be emphasized that the childhood behaviour disorder history is used here as a *yardstick* to measure capacity for emotional discharge. It was not expected that the incidence obtained in the various groups would necessarily accurately reflect the true occurrence rates. Among other things it was realized that memory might be faulty but there is no reason to suspect that lung-cancer patients have better or worse memories than non-cancer patients.

B. *Concealment*

It was also argued that if lung-cancer patients tend to conceal or bottle up their emotional problems, this might be influenced by: (i) general lack of aggression, a feature that has been reported by some workers (Cutler, 1954; LeShan & Worthington, 1956; Trunnell, 1959) to be common to many patients suffering from cancer of one site or another; (ii) diminished opportunity for discussing emotional problems, for instance because of lack of suitable confidants.

Accordingly, the following questions were included:

(i) *Re concealment.* Do you tend to bottle up and keep to yourself your worries, emo-

tional problems, difficulties, etc., or do you tend to talk them over with someone?

(ii) *Re aggression.* (*a*) As a child, did you never fight with other children, did you only fight in self defence, or did you start fights? Which? (*b*) As an adult, do you avoid a quarrel or disagreement at all costs, or do you face up to them?

(iii) *Re sociability* (i.e. taking social intercourse as a guide to potential confidants): (*a*) Would you say you had no friends, some friends, or a lot of friends, which? (*b*) Do you or did you take part in activities with groups of people such as in clubs, associations, etc?

Patients were not required to fill in this questionnaire. The questions were read to each patient and the replies recorded by the interviewer.

The additional use of psychological tests to corroborate any findings relating to these features was felt to be undesirable at this stage for the following reasons: (i) many patients were old and might have difficulty in coping with too extensive a battery of tests; (ii) many were ill and undue prolongation of the interview was undesirable; and (iii) it was not practicable for the interviewer to have each interview unduly prolonged.

RESULTS

Apart from Tables 4 and 7 where analysis of variance is used, the χ^2 test of significance is used throughout, $P < 0.05$ being taken as the lowest acceptable level of significance.

In all the tables, the numbers in parentheses represent the totals in each group. Significant differences, where they occur, are given below each table.

A. *Childhood behaviour disorders*

Incidence. Significantly fewer lung-cancer patients than controls give a history of one or more of the childhood behaviour disorders (Table 1). The same trend is present in each of the three age groups but in none of them is significance reached. In both lung-cancer patients and controls the incidence of patients

who give this history decreases with age, suggesting that memory may play a part in the incidences recorded. However, since the differences between the lung-cancer and control patients are clearly present in all three age groups, memory cannot be the only factor.

Table 1. *Incidence of patients with one or more childhood behaviour disorders*

Age group	All lung cancer		All controls	
	No.	%	No.	%
25–54	17	31·5	42	46·7
	(54)		(90)	
55–64	20	26·7	22	38·6
	(75)		(57)	
65 and over	5	15·6	8	29·6
	(32)		(27)	
All ages*	42	26·1	72	41·4
	(161)		(174)	

* $\chi^2 = 8.29$, $P < 0.01$.
For each age group $\chi^2 = 3.24$, 2.76 and 1.82, P being > 0.05, > 0.05 and > 0.1 respectively, and not significant.

The low rate of childhood behaviour disorders in the lung-cancer group is in keeping with the hypothesis that lung-cancer patients have a diminished outlet for emotional discharge.

Types. Table 2 gives the incidence of patients with each childhood behaviour disorder. There are fewer lung-cancer patients than controls in each of the five childhood behaviour disorder categories. Only in the category 'bed wetting' is the difference significant. Because of smallness of numbers by further subdivision, separation into age groups is not given. To exclude the possibility that the bed-wetting figures might have exaggerated unduly the over-all figures for incidence, a calculation was made of the incidence of patients with a disorder other than bed wetting. This is given in the last line of Table 2. Even excluding bed wetting,

Table 2. *Incidence of patients with each childhood behaviour disorder*

Nature of childhood behaviour disorder	All lung cancer (161)		All controls (174)	
	No.	%	No.	%
Bed wetting*	6	3·7	17	9·5
Fears, phobias, anxieties, etc.	23	14·4	37	21·2
Stammering	6	3·7	8	4·6
Truancy or delinquency	12	7·4	16	9·2
Temper tantrums	7	4·3	12	6·9
Incidence of patients with a disorder other than bed wetting**	39	24·2	64	36·2

$* \chi^2 = 4·89, P < 0·05.$
$** \chi^2 = 6·43, P < 0·02.$

significantly fewer lung-cancer patients than controls had had childhood behaviour disorders.

Relationship with Maudsley Personality Inventory (M.P.I.) findings

In the previous related paper (Kissen & Eysenck, 1962) lung-cancer patients as compared with controls were shown to have a low score for neuroticism and to be somewhat extraverted. ('Neuroticism' according to Eysenck (1959) refers to the individual's general emotional liability, emotional over-responsiveness and liability to breakdown under stress. 'Extraversion' as opposed to introversion, refers to the individual's outgoing, uninhibited social proclivities.) Since both the N scores of the M.P.I. and the childhood behaviour occurrence were used to measure the same feature—the diminished outlet for emotional discharge—it was decided to test the consistency of the findings by working out the M.P.I. scores in relation to the presence or absence of a history of childhood behaviour disorders. Because the present study was started slightly earlier than the M.P.I. study, the total number in the table showing the correlation (Table 3) is less than the total number in the previous tables. Table 3 shows a lower score for neuroticism among those with *no* history of childhood behaviour disorder than had those with such a history. The difference occurs in both lung-cancer and control groups. The over-all difference for extraversion does not quite reach significance.

There is, therefore, a strong correlation between the M.P.I. findings in respect of neuroticism and the low incidence of childhood behaviour disorders.

Table 3. *Extraversion and neuroticism scores with standard deviations according to childhood behaviour disorder occurrence*

	With no childhood behaviour disorder				With childhood behaviour disorder			
	E		N		E		N	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Lung cancer	7·63 ± 2·68 (109)		2·84 ± 3·02		7·45 ± 2·45 (38)		5·11 ± 3·98	
Controls	7·54 ± 3·00 (87)		4·00 ± 3·73		6·62 ± 3·15 (66)		6·46 ± 3·66	
All (lung cancer and controls)	7·59 ± 2·85 (196)		3·32 ± 3·34		6·92 ± 2·89 (104)		5·96 ± 3·77	

Over-all significances: extraversion—$t = 1·93$ (1·96 = significance at 5 % level); neuroticism—$t = 6·16$ (2·58 = significance at 1 % level).

B. Concealment

Questions regarding concealment were inadvertently begun slightly later than those regarding behaviour disorders, aggression and sociability. There are, therefore, slight differences in the total numbers in these respective groups.

Incidence. Significantly more lung-cancer patients than controls said they tended or conceal or bottle up emotional problems to difficulties (Table 4). The differences occur in all three age groups, significantly so in the age groups 25–54 and 65 and over. The highest proportion of concealers is in the oldest lung-cancer group.

Table 4. *Tendency to concealment of emotional difficulties*

Age group	All lung cancer		All controls	
	No.	%	No.	%
25–54*	30	55·6	34	38·6
	(54)		(88)	
55–64	39	56·5	26	48·1
	(69)		(54)	
65 and over**	23	74·2	11	40·8
	(31)		(27)	
All ages***	92	59·7	71	42·8
	(154)		(166)	

* $\chi^2 = 3·85$, $P < 0·05$.   ** $\chi^2 = 6·93$, $P < 0·01$. *** $\chi^2 = 9·31$, $P < 0·01$.
In age group 55–64, $\chi^2 = 0·94$, $P > 0·1$; not significant.

Relationship with M.P.I. scores

In the lung-cancer group there are no suggestive differences either for extraversion or neuroticism between concealers and non-concealers (Table 5). Among controls, concealers, as opposed to non-concealers, are relatively introverted and neurotic but these differences could be due to chance.

It appears unlikely, therefore, that there is any definite relationship between concealment, as defined here, and M.P.I. scores. The absence of such a relationship suggests that concealment does not measure the same characteristic as do the low neuroticism scores—the diminished outlet for emotional discharge.

Relationship with childhood behaviour disorders

The low incidence of childhood behaviour disorders in lung-cancer patients compared with controls occurs among both concealers and non-concealers (Table 6). Concealers tend to have had somewhat more childhood behaviour disorders than non-concealers, but not significantly so. Since lung-cancer patients

Table 6. *Percentage of patients with childhood behaviour disorder according to concealment tendency*

	Concealer	Non-concealer
Lung cancer	23·4	19·3
Control	54·1	45·7

Table 5. *Extraversion and neuroticism scores with standard deviation according to concealment tendency*

	Concealer				Non-concealer			
	E		N		E		N	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Lung cancer	7·84 ± 2·60		3·40 ± 3·30		7·50 ± 2·74		3·47 ± 3·34	
	(88)		(88)		(59)		(59)	
Control	6·61 ± 3·10		5·72 ± 3·81		7·62 ± 3·01		4·30 ± 3·70	
	(72)		(72)		(81)		(81)	
All (lung cancer and control)	7·22 ± 2·80		4·44 ± 3·51		7·57 ± 2·88		3·95 ± 3·50	
	(160)		(160)		(140)		(140)	

contain more concealers but *fewer* with childhood behaviour disorders there would appear to be no direct relationship between concealment and a history of childhood behaviour disorders.

Thus there is apparently no definite relationship between concealment and either of the two features which measure a diminished outlet for emotional discharge. Concealment appears to be a characteristic distinct from a diminished outlet for emotional discharge.

Lack of aggression

For simplicity, figures were worked out for those who said they *never* fought as children and for those who said they *avoid* quarrels at all costs (Table 7). This is in keeping with the feature under consideration—the *lack* of aggression. No suggestive differences are found between the lung-cancer and control groups. Lack of aggression, as measured here, does not appear to influence concealment.

Table 7. *Incidence of some features relating to lack of aggression and lack of sociability*

Behaviour activity	All lung cancer (161)		All controls (174)	
	No.	%	No.	%
1. Never fought in childhood	37	23·0	40	23·0
2. Avoids quarrelling at all costs	94	58·4	95	54·4
Both 1 and 2 (lack of aggression)	21	13·0	31	17·3
3. No friends	15	9·3	15	8·6
4. No group activities	53	32·3	62	34·6
Both 3 and 4 (lack of sociability)	9	5·6	6	3·4

Lack of sociability

For simplicity, figures are worked out only for those who said they had *no* friends or *never* took part in group activities (Table 7). This, too, is in keeping with the feature under consideration—the *lack* of sociability. There are no suggestive differences between lung-

cancer and control groups. Lack of sociability, as measured here, implies lack of confidants and this does not appear to influence concealment.

The lung-cancer age group 65 and over contains the highest proportion of concealers (see Table 4). It is quite possible that this may be associated with lack of confidants due to the natural tendency, with increasing age, to death of relatives and friends and scattering of family. This cannot be the whole answer because all lung-cancer age groups, including the age group 25–54, contain more concealers than do the controls.

Relationship with cigarette smoking status

In the previous related paper (Kissen & Eysenck, 1962) it was shown from M.P.I. findings that lung-cancer patients were not a random sample of cigarette smokers, because lung-cancer patients had low N scores and somewhat raised E scores, whereas the general cigarette smoking population had high N scores and raised E scores. It might still be argued that the various personality differences between lung-cancer and non-cancer patients could be due to a preponderance of cigarette smokers, who are also *heavier* smokers. That is to say the personality differences between lung-cancer patients and controls might be due to differences between a group of heavy cigarette smokers (lung cancer) and a group of light cigarette smokers (controls). This would be contrary to what Eysenck, Tarrant, Woolf & England (1960) found for the general population of cigarette smokers, viz. that both N scores and E scores, especially the latter, tend to increase with the amount smoked.

The various scores and incidences were, however worked out in terms of cigarette smoking status. Using Doll & Hill's (1952) definition of a cigarette smoker (that is a person who has smoked at least one cigarette daily for at least one year), Table 8 confirms the frequent findings of a higher incidence of cigarette smokers and a higher rate of cigarette smoking among the lung-cancer patients.

Table 8. *Percentage smokers*

	Non-smoker	Cigarette smokers			Pipe only smoker
		1–14 daily	15–24 daily	25 & over daily	
Lung cancer	2·3	19·2	46·3	30·3	1·9
Control	8·3	29·9	39·7	17·6	4·5

Table 9. *Scores according to cigarette smoking status*

	Non-smoker				1–14 daily			
	N	E	C.B.D.	C	N	E	C.B.D.	C
Lung cancer	2·50	8·89	20·0	100·0	3·57	7·27	26·2	59·0
Control	4·70	7·88	53·0	14·2	4·71	6·49	44·3	47·5

	15–24 daily				25 and over daily			
	N	E	C.B.D.	C	N	E	C.B.D.	C
Lung cancer	3·46	7·19	34·7	59·4	3·76	7·37	22·7	54·5
Control	5·09	7·19	51·8	40·7	5·28	7·47	47·2	44·4

N = means for neuroticism (M.P.I. short form).
E = means for extraversion (M.P.I. short form).
C.B.D. = percentage of patients with history of childhood behaviour disorder.
C = percentage of concealers.

M.P.I. scores for neuroticism and extraversion, and percentages for childhood behaviour disorders and concealment, show the differences between lung-cancer patients and controls to be consistent at all levels of cigarette smoking (Table 9).

Among the controls, mean N scores show a gradual increase according to quantity smoked, and if one excludes non-smokers the mean E scores also show increase with quantity smoked and are consistent with the findings of Eysenck *et al.* (1960) for cigarette smokers in general. (The non-smokers constitute a very small group and the high E score is probably due to chance.) Among the lung-cancer patients this trend is less certain. Although the heaviest smoking group contains the highest mean N scores and also (except for the very small group of non-smokers) the highest mean E scores, the differences at other levels of cigarette smoking

are very slightly in the opposite direction. However, the M.P.I. N and E scores, and the childhood behaviour disorder and concealment rates, show that the differences between the lung cancer patients and controls are consistent at all levels of cigarette smoking.

It is clear therefore that the personality differences between lung-cancer patients and controls are independent of cigarette smoking status.

Because of the very small numbers both of lung-cancer and control patients smoking only a pipe, scores for pipe smokers are excluded.

Relationships with tumour histology

The various scores and incidences were also worked out in relation to tumour histology (Table 10). Tumours are classified as adenocarcinoma, squamous, or undifferentiated. There are no suggestive differences between the three histological groups in respect of concealment or E scores. Although the adenocarcinoma group has a somewhat lower capacity for emotional discharge on both measures, the differences are not significant.

There is, therefore, no apparent relationship between tumour histology and these various features of personality.

Table 10. *Scores according to tumour histology*

| | Capacity for emotional discharge | | | Conceal- |
	Mean N	C.B.D. %*	Mean E	ment %*
Adeno-carcinoma	3·00	20·0	7·40	60·0
Squamous	3·34	27·0	7·01	60·3
Undifferen-tiated	3·89	26·7	7·62	60·0

* Percentages are expressed in terms of total numbers in each histological group.

DISCUSSION

The findings reported here show two main features among the lung-cancer patients as opposed to the non-cancer controls. Firstly, there is a lower incidence of certain childhood behaviour disorders. Secondly, there is a high rate of concealment, or bottling up, of emotional difficulties. These findings appear to be independent of cigarette smoking status and of tumour histology; nor is there any apparent relationship with lack of aggression or lack of sociability as defined in this study. In other words, the findings support the two hypotheses referred to at the beginning of this paper—that lung-cancer patients have a poor outlet for emotional discharge and that they tend to conceal or bottle up their emotional difficulties. It should be emphasized that these hypotheses were based on clinical observation of about 300 chest patients, of whom about half had lung cancer.

The nature of the childhood behaviour disorders in that they can be readily seen to represent early outlets for emotional discharge, and the strong statistical correlation of their low incidence with low neuroticism scores as measured by the M.P.I., suggest that both yardsticks employed to measure the diminished outlet for emotional discharge were in fact measuring this characteristic. In other words, the statement that lung-cancer patients, in contrast to non-cancer patients, have poor capacity for emotional discharge, is supported by clinical observation in the first instance, and two subsequent independent objective measures.

In the previous related report (Kissen & Eysenck, 1962) the low neuroticism scores were shown to be somewhat modified by a history of psychosomatic disorders. In the study reported here, this was also found to be true of the childhood behaviour disorder incidence, but as it does not affect the main theme of this paper and might be confusing, details are not given here.

If, however, the concealment incidences in the lung-cancer patients and controls respectively are subdivided according to the presence or absence of a history of psychosomatic disorders, then distinct differences are seen as follows.

Both lung-cancer groups show concealment incidences of between 59 and 60 %. The control groups, however, show incidences of 51 and 33 % in those with and without a history of psychosomatic disorders. The lower incidence of concealment in the 'non-psychosomatic' controls compared with the other three groups is quite significant, P being less than 0·01. It would appear therefore that a tendency to concealment is a feature that lung-cancer patients have in common with patients giving a history of psychosomatic disorders. Moreover, such concealment, elicited as it was in this study by direct interrogation of patients as to whether or not they conceal, implies a *conscious* awareness of this feature. The absence of a definite relationship between concealment and M.P.I. scores, and between concealment and childhood behaviour disorder occurrence, suggests that, by and large, concealment is a feature distinct from diminished outlet for emotional discharge.

A diminished outlet for emotional discharge, as measured by neuroticism scores and childhood behaviour disorder incidence, is a characteristic that is shown in the study

reported here and in the related study to be peculiar to the lung-cancer patients as opposed to non-cancer patients. It must have been present in the individual for a long time and is something over which the individual has no conscious awareness. It is relevant to mention that this characteristic feature of lung-cancer patients has been observed independently by Bahnson when working in Boston, Mass. (P. H. Knapp, personal communication). Bahnson's observations were made in about twenty cases of lung cancer but because of practical difficulties he was unable to follow up his clinical observation with controlled studies (C. Bahnson, personal communication).

Whether or not this poor capacity for emotional discharge is also a characteristic of cancers of other organs cannot be answered here. On the one hand, Sainsbury (1960) in a small series of nineteen unspecified cancers, presumably of different sites, reported mean *N* scores on the M.P.I. with a tendency towards being high rather than low. On the other hand, LeShan & Worthington (1956), referring to a report by Elida Evans (1926) on 100 cases of cancer, presumably of varying sites, who had been evaluated through intensive psychotherapy, state that a feature of these patients was that '...there was no outlet for psychic energy'.

Why such a feature should occur in these people, why it should find expression in these people in the form of lung cancer, what the mechanism might be, or what might be the nature of the pathway between emotion and cancer and no doubt many other questions can be posed but not answered here.

My studies in these patients still proceed. Much material of a psychosocial nature has yet to be fully analysed for a much larger number of patients than has been considered in this paper. When this has been done, perhaps some further light may be shed on the problem of psychological factors in cancer.

Before concluding, it should be made clear that the psychological findings in lung cancer that I have described in this paper are not put forward as a challenge to any other findings or theories. They are quite consistent with a multifactorial aetiology of lung cancer. Nor is it suggested that the factors described here are necessarily the only psychological ones.

SUMMARY

One hundred and sixty-one male lung-cancer patients and 174 male non-cancer patients in three hospital chest units were studied in respect of: (i) a history of certain childhood behaviour disorders, and (ii) concealment of emotional difficulties.

These studies were designed to test features hypothesized from material elicited by previous clinical observation of about 150 lung-cancer patients and an approximately similar number of controls.

The data were elicited before the investigator was aware of a diagnosis and mostly before a diagnosis of lung cancer was confirmed.

There was no deliberate selection of patients, nor were there any suggestive social class or occupational differences.

Fewer lung-cancer patients gave a history of a childhood behaviour disorder, especially bed wetting, than did the controls.

Lung-cancer patients, in common with controls with a psychosomatic history but in contrast to controls with no psychosomatic history, admitted to a conscious tendency to conceal or bottle up emotional difficulties. Such concealment is apparently uninfluenced by lack of aggression or lack of sociability. Lack of confidants, especially in old people, may contribute to concealment.

The findings both for childhood behaviour disorders and concealment do not appear to be influenced by cigarette smoking status, nor is there any suggestive relationship with tumour histology.

There is a marked statistical correlation between absence of a childhood behaviour disorder history and the low mean score for neuroticism previously reported in these patients by Kissen & Eysenck. Both these

measures were used to test the hypothesis that a characteristic feature of lung cancer patients is a diminished outlet for emotional discharge, and the findings support this hypothesis. This characteristic feature of lung-cancer patients appears to be an unconscious phenomenon.

It is emphasized that the psychological factors dealt with in this paper are not suggested to be other than elements in a multifactorial aetiology.

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The denial of illness

By ISABELLE V. KENDIG*

Writing in 1938, Schilder[29] stated that 'the problem of physical health has never been studied in its psychological aspect'. In general this still holds for, understandably, it is the pathological upon which attention is most easily focused. Thus the many investigations growing out of psychosomatic theory have been concerned with relating various disease syndromes to specific personality patterns. More recently attention has turned to the role played by socio-environmental factors in the causation of disease. Wolff[35], for instance, lays emphasis upon the critical significance of 'life stress' situations and the findings of Hinkle[14, 15, 16, 17, 31, 32] and his co-workers support the view that illness ensues when external stress results in a breakdown of the individual's defences. Status factors have also been found to be related to disease incidence. While Ruesch[26, 27] holds that the 'infantile personality' is the core problem of psychosomatic medicine, in a study of 187 cases of so-called 'delayed recovery' he found that 75% of this group belonged to the lower middle class as compared to 28% in the general population. His conclusion is that flight into illness and delayed recovery represent a defence characteristic of this stratum of society. Since the

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publication of this paper Rennie & Srole[23], in an epidemiological survey of eleven common ailments, found four clear-cut patterns of distribution, apparently a function of socio-economic class.

All such investigations, however, are primarily directed to the exploration of psychological and social factors contributory to the aetiology of disease, not with the problem of health *per se*. The study reported here has a somewhat different focus. It is concerned with investigating the development of certain attitudes to the self and to the body which may lead to the *denial* of illness, and with the results of such denial upon the maintenance of subsequent health.

'Denial of illness' as a pathological syndrome has been intensively studied and indeed inspired the title of a recently published book by Weinstein & Kahn[33, 34]. It deals largely with what is more technically called 'anosognosia', the total denial of their infirmity by occasional patients suffering from paralyses, blindness, amputations, etc. The term was originally used by Babinski[1, 2] in an even more limited sense to denote denial or unawareness of left hemiplegia resulting from a lesion in the right hemisphere. Other writers such as Pick[22] and Head & Holmes[13] considered the syndrome due to a disturbance in the 'body scheme' which they believed to have a three-dimensional representation in the parietal lobes or in the thalamus. Schilder[28], however, and Goldstein[10] have both attempted to explain anosognosia more dynamically as a psychological mechanism by which painful facts are excluded from consciousness. As a result of their study, Weinstein & Kahn[33] conclude that 'the effect of the brain damage is (merely) to provide the milieu of altered function in

which the patient may deny *anything*', adding that 'Some motivation to deny illness and incapacity exists in everyone...'. In an investigation of the pre-morbid personalities of their patients they found that of those particularly who made explicit verbal denial: 'All had previously shown a marked trend to deny the existence of illness. They appeared to have regarded ill health as an imperfection or weakness or disgrace. Illness seemed to have meant a loss of esteem and adequacy.... The maintenance of health seemed to be a kind of moral or ethical duty and illness represented not only unhappiness and danger but a sin.' In patients where denial was most complete, they found the prevailing mood affable and serene.

No such technical use of the concept 'denial of illness' is intended in this study. Rather it is here defined in terms of common usage represented by such phrases as 'No, I am not sick', 'It (a symptom) is of no consequence', 'I feel fine'. This last is an affirmation of health and positive statements of this sort are commonly found in conjunction with the tendency to deny illness. It is as though any evidence of the latter were brushed aside in favour of a statement of general well-being.

This colloquial use of the term 'denial of illness' is also in sharp distinction to its use by Christian Scientists for whom it expresses, in accordance with their tenets, negation of the *reality* of disease. (The effect upon health and longevity of such a radical doctrinal position has unfortunately never been explored although as long as thirty years ago Clark Hull[20], the Yale psychologist, recommended 'a sympathetic yet scientific study of what actually can be accomplished by adept Christian Scientists in their own bodies'.)

No experimental studies were found in the literature designed expressly to investigate the effects upon subsequent health of the tendency to deny illness and affirm general well-being in the colloquial sense defined above. However, a USPHS report touches upon the prevalence of such attitudes as they are encountered in community interviews. It presents the findings in a so-called socio-psychological survey of the extent of utilization of X-ray facilities for the detection of tuberculosis. Among 1009 respondents interviewed, Hochbaum[18] found nearly a third (29%) convinced that they could not or would not contract TB. This attitude represents a denial of the possibility of illness, an implied affirmation of health, which contrasts sharply with that of the large number of subjects they found who showed varying degrees of apprehension that they themselves might become victims of the disease. Certainly such attitudinal differences are to be found in all groups. There are those who appear confident of continued health, who make light of such illnesses as may befall them, and there are those who fear the worst however minor the hazard—draughts, wet feet, unaccustomed foods, etc. (Parenthetically, one wonders to what extent such fearfulness may not be accentuated by the constant reiteration by medical and public health agencies, through all our media of communication, of the need for frequent physical check-ups to detect the early symptoms of disease and by the publicity drives which designate certain weeks as epilepsy week, cancer week, multiple sclerosis week, etc., thus keeping the concept of disease constantly before us.)

In any case the results of the USPHS survey raise a number of challenging questions, perhaps most importantly: (1) What is the background of life experience which leads to such converse attitudes? (2) What is their objective effect, if any, upon subsequent health?

The latter question leads directly to a consideration of the efficacy of the idea in producing physical change. Freud speaks of this as 'the mysterious leap from psyche to soma'.

Much has been written about the potency of the idea, whether endogenously derived or mediated through suggestion. One of the boldest statements of the all-powerful role of the idea was made many years ago by the great French physiologist, Claude Bernard [4], who asserted that: 'In every living germ

is a creative idea which develops and exhibits itself through organization. As long as a living being persists it remains under the influence of this same creative vital force, and death comes when it can no longer express itself; here, as everywhere, everything is derived from the idea which alone creates and guides.'

Equally unequivocal is the statement of a distinguished psychologist, the late H. H. Goddard[9], that 'any idea possessing the mind tends to materialize itself in the body'. Further, and bearing directly upon the problem under study here, is his formulation of the Law of Suggestion: 'The idea of health tends to produce health in proportion to the strength of the idea, or inversely as the opposition to be met.' Certainly current use of hypnotic techniques shows them capable of producing a host of physical changes in the body from removing warts to inducing herpetic lesions generally considered purely viral. Of present interest also is the so-called 'placebo effect' which appears to be another manifestation of the power of suggestion.

However, the most dramatic instances showing the controlling force of the idea come to us from the anthropologists. Thus Rivers[25], writing on demonological procedures, states that such practices are efficacious and by their aid diseases may be caused and cured. 'Men who have offended one whom they believe to have magical powers sicken, and even die, as the direct result of their belief....' This is an area in which Cannon[5], a physiologist like Bernard, was interested as disclosed in his article on 'Voodoo' Death published in 1942. At a meeting of the American Psychosomatic Society in 1956, held in Cannon's honour, Curt Richter [24] presented a paper 'On the phenomenon of sudden death in animals and men' in which he ascribed its occurrence to 'hopelessness'. This to be sure is an emotion, but back of the emotion lies an idea or belief. And both Cannon and Richter have proposed physiological mechanisms to explain how such symbolic stimulation is mediated. The former

believed it was accomplished through the activation of the sympathetic nervous system, the latter through parasympathetic action. Of course there are many who doubt the very phenomenon of psychogenic death. A recent note by Barbei [3] in *Psychosomatic Medicine* discounts the scientific accuracy of the reports of the anthropologists and suggests that sudden and mysterious death in men who believe themselves doomed because they have broken a taboo or offended an enemy can be explained on the grounds that they had an unrecognized disease, or had been poisoned, or died of starvation and dehydration because of their refusal to eat. However, his argument fails to explain away the sudden deaths of Richter's experimental rats in situations producing intense fear.

THE HYPOTHESIS

The hypothesis underlying the present study is that belief in the integrity of the self and the invulnerability of the body may make a positive contribution to the maintenance of health. This invokes two concepts, both of theoretical interest in this context.

The self-concept is stimulating a great deal of current research especially as regards the changes in it effected by psychotherapy. Indeed it is now generally held that to accept and like one's self is pre-requisite to the acceptance of others and basic to healthy adjustment. Recent experimental studies such as those of Secord & Jourard [30] indicate that the body and the self are cathected to the same degree.

The concept of the 'body scheme', already alluded to, or the 'body image' as it is now more generally called, was most fully developed by Schilder[28], but Head[12] and Critchley[6, 7] in England have also been concerned with it. According to Schilder, the emotional life 'plays an enormous part in the final shaping of the postural model of the body'—but 'The development of the body-schema probably runs to a great extent parallel with the sensory-motor development'. It was on this premise that Goodenough[11]

constructed the Draw-a-Person test for children as a measure of mental age. Most frequently the phantasy picture for the human body is a building with its walls, bricks and beams—the house. However, transformations such as occur universally in fairy tales show the plasticity of the body image and it is not uncommon for psychotics to believe themselves transformed into animals. Normally, however, as Critchley[6] points out, the body image develops slowly in the child and lingers on in old age frequently little modified. In proof of this he has collected examples of the many artists who continue through life to paint themselves as they were when young. In experimental studies of patients suffering from various diseases, Fisher & Cleveland[8] have adduced evidence that 'organ choice' can be related to opposing concepts of the body. Those who regard it as a barrier tend to suffer from various skin disorders and diseases affecting the skeleto-muscular system like arthritis, while those who regard the body as penetrable fall victim to diseases of the internal organs.

THE EXPERIMENTAL DESIGN

In order to test the hypothesis that belief in the integrity of the self and the invulnerability of the body is perhaps one among the many factors which play a positive role in the maintenance of health, it was planned to study groups of patients seriously ill with various chronic disorders together with controls closely matched on all important variables, except that the latter should be functioning in the community as relatively healthy individuals. Circumstances made it possible to set up two experimental groups, the one consisting of patients suffering from rheumatoid arthritis, the other from leukemia. Both are diseases of unknown aetiology.

The original intent was to use standard psychological techniques in the effort to evaluate and contrast the self-concept and the body image in the healthy and the sick. Hence in a pilot study the Rorschach, the Draw-a-Person, and the Four Picture tests were employed. However, what soon suggested itself, in beginning work with the rheumatoid group, was that in patients long crippled with arthritis the self-concept and body image might have suffered severe denigration and would thus reflect the *effects* of the disease process, that is, derivative attitudes rather than determinative ones. It therefore became necessary to recast the experimental design and, open as the method may be to criticism, to attempt a retrospective study based upon interview procedures. The inquiry was directed to an exploration of the events and forces playing upon the individual during the first 18 years of life with special emphasis upon family attitudes to illness which theoretically could be expected to raise or lower the subject's self-esteem and confidence in his own well-being.

THE STRUCTURED INTERVIEW

Having decided upon a retrospective study based upon a structured interview, a series of six detailed interview schedules, comprising 120 questions in all, was drawn up dealing with the following general areas:

Schedule A—Infancy and early development.
Schedule B—Religious background.
Schedule C—Family attitudes to illness.
Schedule D—Personal experience of illness.
Schedule E—Early experiences of death.
Schedule F—Psychosexual development.

Following a pilot study in which the interviewing was done by the principal investigator, the interviews were conducted by two research assistants, both experienced psychologists with graduate degrees, carefully trained in the latitude allowed for probe questions when additional information was desired. Each interview lasted approximately an hour and a half and was tape-recorded. Subsequently all identifying information was deleted from the protocols by a student assistant to make possible 'blind' scoring of the data.

THE NATURE OF THE SCHEDULES

Schedule A—Infancy and early development. After eliciting information re nativity, education and occupation of the parents in order to determine the socio-economic status of the family, this schedule develops a general background history of the subject's first 18 years. While largely factual it also probes into his reactions as, for example, to the discipline he received, family conflicts, etc.

Schedule B—Religious background. Besides establishing his church affiliation, this schedule explores the religious pressures to which the subject was exposed such as membership in a minority faith, compulsory prayers and attendance at Sunday school and church, and the inculcation of feelings of guilt and fear over wrong-doing.

Schedule C—Family attitudes to illness. This schedule specifically investigates the extent of illness in the family, parental attitudes to medication, hospitalization and surgery, reliance upon a 'Doctor Book', etc.

Schedule D—Personal experience of illness. This schedule covers the subject's own history of illness, medication, hospitalization and surgery, his feelings about his health and how it was regarded by his parents, his utilization of illness for escape from school, chores, etc.

Schedule E—Early experiences of death. This schedule deals with deaths occurring in the family circle, among school-mates and friends and attempts to evaluate the extent of the resulting trauma to the subject.

Schedule F—Psychosexual development. This schedule seeks to obtain data not only on the subject's own sexual development but on family attitudes toward sex. It was drawn up in parallel forms, one for men, one for women, to permit differentiation particularly of pubertal experience.

SCORING—DEVELOPMENT OF SCALES

In order to quantify the interview data, numerical scores were assigned to responses considered pathological, that is to those reporting circumstances or reactions deemed detrimental to the self-concept and/or the body image, including those indicating morbid preoccupation with illness on the part of the subject or his family. Clearly, however, to treat such scores additatively would often be to total apples and oranges since they relate not only to different areas but to different levels of experience. Six scales were therefore devised under which responses could be appropriately classified and scored. Scales I and II, in Murray's [21] terminology, deal respectively with impersonal and personal press (p and P). Thus, death (schedule E) or divorce of the parents in the subject's childhood (schedule A) were scored as small p (impersonal press) under scale I; punishment for bed-wetting (schedule A) or compulsory church attendance (schedule B) as capital P (personal press) under scale II. Scale III scores for such deviant traits in early childhood as bed-wetting, nail-biting, stammering, etc., which may reflect and are certainly productive of early impairment of self-esteem. Scale IV measures the subject's expressed anxiety and/or guilt reactions, for instance, over parental discord or childhood masturbation (both schedule A). Scale V, again in Murray's nomenclature, attempts to score for dependency (n Succorance) as chiefly reflected in expressed enjoyment of illness (schedule D). While such a scale does not necessarily relate to denigration of the self-concept or body image, it does indicate early pre-possession with the utilization of illness as a means of escape in conflict situations. The last scale (VI) was included to measure positive attitudes to the self and to illness and interest in caring for others (n Nurturance) rather than the need to be cared for (n Succorance). It was not used in computing pathology scores but was used in the subsequent analysis.

The numerical scores assigned were arbitrarily weighted to reflect the degree of pathology inferred in scales I to V, the strength of denial of illness, of the affirmation

of health, in scale VI. Thus, death of the mother in early childhood (schedule D, scale I) was given 3, death of the father, 2; physical punishment as the principal mode of discipline (schedule A, scale II), 1; enuresis (schedule A, scale III) after infancy, 1, into grade school, 2, into high school, 3; in the anxiety scale (IV) a weighting of 1 was assigned to 'mildly disturbed', of 2 to 'very disturbed'; in scale V, pretence of illness was scored 1 when 'occasional', 2 when 'often'; in scale VI, on the other hand, denial of illness, affirmations of health, were scored 1 when 'occasional', 2 when 'often'.

As noted above the scoring was blind. All protocols (148) were scored by the principal investigator from a play-back of the tapes. Of these, 104 were also scored independently by two trained psychologists, 74 by one and 30 by the other. Their ratings, compared with those of the principal investigator, yielded a reliability coefficient of 0·91 (Spearman). Thereafter, in the final analysis of the data, the scores of the principal investigator were used.

THE EXPERIMENTAL GROUPS

There were two experimental groups:

(1) Fifty patients hospitalized in the National Institute of Arthritis and Metabolic Diseases under treatment for rheumatoid arthritis.

(2) Twenty-four patients hospitalized in the National Cancer Institute under treatment for leukemia.

Essentially the cases in each group represent consecutive admissions except that children were excluded and in a few instances exceptions were made at the request of Staff because individual patients were either too emotionally disturbed or too ill to be interviewed. All who were accepted for the study were required to be over 18 years of age, mentally competent, and able and willing to co-operate in the interview situation.

The final make-up of the groups was as shown in Table 1:

Table 1

	Arthritis (50)	Leukemia (24)
Sex: Males	21	17
Females	29	7
Race: White	46	23
Negro	4	1
Age: Median	45	38
Range	26–66	19–64
Religion: Protestant	42	20
Catholic	8	2
Jewish	0	2
Education: Under 7 grades	7	4
7–12	26	12
College, Professional	17	8
Index of social position:		
Class I	3	2
Class II	6	3
Class III	15	8
Class IV	11	5
Class V	15	6

THE CONTROL GROUPS

Controls were drawn from among current employees at the National Institutes of Health. Personnel records were consulted and suitable individuals contacted by the interviewers and invited to participate in the research project on a volunteer basis. Confidentiality being assured, the majority of those approached assented readily and proved most co-operative.

Patients and controls were *individually* matched on six variables—sex, race, age, religion, education and occupational level. A leeway of 5 years had finally to be allowed in matching for age. As regards educational and occupational groupings, Hollingshead's[19] classification was used. This resulted in approximate matching on a 7th variable—viz. social position, as shown in Table 2.

In the end we found that approximately 50% of our subjects were drawn from classes IV and V, around 80% from class III and below. This is only roughly proportionate to

Table 2

Class*	General population (%)	Arthritis (%)	Controls (%)	Cancer (%)	Controls (%)
I	2·7	6	4	8·3	8·3
II	9·8	12	16	12·5	8·3
III	18·9	30	26	33·3	37·5
IV	48·4	22	28	20·8	20·8
V	20·2	30	26	25·0	25·0

* Roughly, in terms of occupation, these classes stand for professional (I), sub-professional (II), skilled (III), semi-skilled (IV) and unskilled (V) but education is also taken into consideration so that the final score used is a composite one. It is perhaps of interest that matching for occupation largely precluded the use of nurses. There were just two nurses among the fifty arthritic patients and so only two in the control groups; none at all in the leukemia study.

the size of these classes in the general population where 68% are estimated to be in IV and V, 87·5% in class III and below. Or putting it the other way around a somewhat disproportionately large number of our patients and controls came from the two highest classes—I and II.

and AC-1, and the second groups of 25 as A-2 and AC-2. It was hoped that the findings from an analysis of the first would be replicated in the second. The 24 cancer patients (C) and their matched controls (CC) were dealt with as a unit.

(1) Of immediate interest were the mean pathology scores for patients and controls. In view of the organization of the data not only could a total pathology score be derived for each individual but this could be broken down by schedules and by scales. Inspection of the means shows that in almost all categories, including that dealing with personal experience of illness (schedule D), the *pathology scores run slightly higher for controls than for patients*, as seen in Table 3.

The few instances (9 out of 72) in which the patients score higher are starred, but the differences neither way are statistically significant. It may be of some clinical interest, however, that both groups of arthritic patients reported harsher and more authoritarian parental attitudes than their controls, and that arthritic males experienced greater difficulty in psycho-sexual development.

(2) Following this rough over-view of the

Table 3. *Comparison of mean pathology scores of patients and controls by schedules and scales*

Subject	No.	Schedules							Scales				
		A	B	C	D	E	FF	FM	I	II	III	IV	V
A-1	25	16·3	11·8	8·2	7·7	8·0	19·9	16·3*	16·2	26·5*	13·2	11·2	3·4
AC-1	25	19·3	11·8	10·7	8·2	8·2	21·2	15·9	18·9	25·9	14·6	14·4	3·6
A-2	25	17·2	12·6*	8·9*	6·8	6·1	20·6*	14·2	18·2*	23·6*	13·8	11·3	2·3
AC-2	25	19·4	12·0	7·6	6·9	8·1	18·3	15·1	16·8	23·3	15·8	12·1	2·9
C	24	17·7	11·7*	9·5	6·0	6·5	14·0	16·6*	16·9	23·2	13·4	11·5	2·5
CC	24	22·5	11·2	10·4	8·2	8·0	23·8	16·0	21·3	24·6	17·0	13·3	3·0

ANALYSIS OF DATA

Because new patients were admitted slowly to the arthritis ward and matched controls took time to find, analysis of the data was begun as soon as the first 25 cases and their individually matched controls were interviewed. These first groups were known as A-1

data, they were submitted to item analysis. Here a few differences, about a dozen in all, significant at the 0·05 level, were found between patients and controls. However, they appear to be due purely to chance since there is no consistent replication from group to group.

(3) In view of these generally negative findings, a new approach was made to the data. It was recognized that the interview schedule as a whole covered such a wide range that gross pathology scores tended to obscure and cancel out small differences and that in item analysis these differences, which taken together might pile up significantly, were also lost. It was therefore determined to examine limited clusters of items, highly focused and bearing more directly upon the areas under investigation. Accordingly, carefully selected items, many used in more than one constellation, were clustered in 8 scales as follows:

(a) *Detrimental to the body image*. Here were included such items as underweight at birth, sickly in infancy, parents 'chronic worriers' about subject's health, felt self physically unattractive to the opposite sex, rejected pubertal changes, made efforts at physical improvement.

(b) *Detrimental to the self-concept*. This scale included status factors such as parents foreign born, unschooled and unskilled, divorce of parents, poverty of family, reared by relatives or institutionalized, etc.; and parental denigration, items indicating parental ridicule, disapproval and punishment for childhood behaviour, favouritism for other siblings, etc. In short, such reactions as were once poignantly described by a schizophrenic patient who said, 'My parents always gave me the failing word in life'.

(c) *Anxiety scale*. This was made up of highly selected items from scale IV in the original interview form.

(d) *Loss of emotional support in childhood*. This repeated many of the items used in scale (b)—separation or divorce of parents, favouritism for other siblings, loss by death of significant figures, etc.

(e) *Morbid family focus upon illness and death*. This covered such items as much family discussion of illness and death, habitual use of medicine, morbid fear of hospitalization and surgery, illness and death in the family, over-concern with bowel regularity, food taboos, etc.

(f) *Enjoyment of illness*. This cluster is self-explanatory, embracing expressions of enjoyment of the attention resulting from illness, also pretending to be sick, preferring the role of the patient in doctor games, etc.

(g) *Role disturbance* (F and M forms). This is also generally self-explanatory, covering such items as being considered a 'sissy' or 'tomboy' in childhood, rejection of pubertal changes, disturbed relations with the opposite sex in adolescence, etc.

(h) *Denial of illness* (positive attitudes to the self). This cluster requires some elaboration. In the original set of scales, VI was tentative. It was designed to measure denial of illness, affirmations of health, and interest in illness based only upon n Nurturance. Since it proved difficult to handle statistically in conjunction with the scales measuring pathology, it was temporarily laid aside. Now the conviction returned that more careful account should be taken of positive feelings about health, usually spontaneously offered in the interview situation, as distinguished from the morbid attitudes which built up into high pathology scores. Therefore, in the cluster analysis, the following set of 14 items were selected to represent those influences and attitudes assumed to be productive of or, in turn, illustrative of a healthy self-concept and an image of the body as intact and relatively invulnerable. The items chosen were the following:

(i) Subject unconcerned about violation of family health measures.
(ii) Unconcerned about bowel irregularity.
(iii) Unconcerned about diet and food taboos.
(iv) Unconcerned about dirt and germs.
(v) Denied illness whenever possible.
(vi) Felt had good health.
(vii) Felt would live to a ripe old age.
(viii) Considered healthy by parents.
(ix) Minor injuries made light of by parents.
(x) Felt self popular with the opposite sex.

(xi)   Pleased at menarche (F–F).
(xii) Pleased at pubertal changes.
(xiii) Satisfied with the body—would not change it.
(xiv) Confident of future.

When cluster analysis was undertaken and the pathology scores of the 50 arthritic patients and their individually matched controls were compared, using the t test, none of the first seven clusters yielded any significant differences. The same negative findings obtained for the 24 cancer patients and their matched controls. However, scores on the last cluster—Denial of illness (positive attitudes to the self)—differentiated controls from patients in each of the groups at a high level of significance, the controls reporting a far more affirmative attitude to the self during the first 18 years of life than either patient group. There was little overlap, only four patients in the arthritic group and 3 in the cancer having a mean score higher than the mean for their controls, while 74% of the arthritic controls and 75% of the cancer controls showed a positive difference in score:

	Arthritis study	Cancer study
N	50	N 24
$\overline{x}$	3·20	$\overline{x}$ 2·83
S.D.	27·60	S.D. 27·60
t	5·74	t 3·37
$\overline{P} <$	0·001	$\overline{P} <$ 0·01 > 0·001

Following are random samples of the type of responses upon which the above findings are based:

Arthritis controls

Denied illness—hid fact he had typhoid for 2 weeks.
Denied illness whenever possible—'still do'.
Considered by parents to have excellent health.
Parents minimized injuries.
Always felt she would never get sick.
Violated health measures—'hasn't worn rubbers more than 4 or 5 times'.
Not worried about bowel irregularity.
Not at all concerned about dirt and germs.

Expected to live to ripe old age.
No defects—would not have changed body.
Happy to be growing up.
All the (self) confidence in the world.
'Pretty proud of self.'
'Quite pleased with self.'
Not really pretty but 'could get any boy away from any girl'.

Cancer controls

Denied illness whenever possible.
Parents thought him 'healthy as a bear'.
Parents took injuries 'lightly'.
Parents wanted him to play rough games.
'Never gave health a thought.'
Thought himself 'the strongest one ever born'.
Expected to live to be a hundred.
Violated health measures—had sense of 'getting away with it'.
Did not worry about bowel irregularity.
Not concerned about dirt and germs.
Quite pleased at pubertal changes.
Liked girls—comfortable with them, and sure they liked him.
Lots of girl friends—felt 'confident, very confident'.
'Moved away and left some very devoted sweethearts'.
Thought she would be 'very successful'.

DISCUSSION

In discussing the results of the investigation, it is perhaps unnecessary to point out that this is not a study of the psycho-etiological factors in rheumatoid arthritis or in leukemia *per se* nor an attempt to compare these groups. It is an effort to explore such differences as may exist between those who remain relatively well and those who fall ill of whatever disease, in the attitudes developed toward the body and toward the self in early life.

It is of interest that the pathology scores of the controls, even as regards personal experience of illness, are generally, though not significantly, higher than those of the experimental subjects suggesting that their experien-

tial background had been equally if not more traumatic. Thus it is not possible to look in this direction for the explanation of their greater self-esteem and their faith in their essential healthiness. Of course in any study of this type the possibility of retrospective falsification must be considered. If it exists here to any significant extent it involves something of a paradox for it would seem to run in opposite directions within each group. Thus we would have to assume that the controls maximized the difficulties of their early years, on the one hand, yet minimized the damaging effects therefrom on the other, while the patients did the reverse.

Only two items of the fourteen in the cluster upon which the positive findings are based reflect parental attitudes. They were considered healthy by their parents and the latter tended to make light of such minor injuries as they sustained. All other items bespeak self-confidence apparently endogenously developed. The data presented support the hypothesis that denial of illness arising from belief in the integrity of the self and the invulnerability of the body is associated with the maintenance of health. One question which immediately presents itself is how such affirmative attitudes, which appear to be largely independent of life experience as here explored, are derived.

SUMMARY

The purpose of this study was to explore experiential and attitudinal factors present in the first 18 years of life which might have a bearing upon subsequent health. The specific hypothesis set up was that belief in the integrity of the self and the invulnerability of the body may make a positive contribution to the maintenance of health.

The design involved the study of groups of subjects seriously ill with various chronic disorders together with controls individually matched on all important variables except that the latter should be functioning in the community as relatively healthy individuals.

The technique employed was the structured interview tape-recorded. For this a set of six schedules was developed dealing with: (A) Infancy and early development; (B) Religious background; (C) Family attitudes to illness; (D) Personal experience of illness; (E) Early experiences of death; and (F) Psychosexual development. This last schedule was prepared in two forms, one for men, one for women, to permit differentiation particularly of pubertal experience. Six scales were also devised under which responses to the interview questions could be appropriately classified and scored in terms of: (I) Impersonal press; (II) Personal press; (III) Deviant traits; (IV) Anxiety; (V) n Succorance; and (VI) n Nurturance. Numerical scores were assigned and arbitrarily weighted to reflect, in scales I to V, the degree of pathology inferred, in scale VI positive attitudes to the self and to others.

There were two experimental groups: (1) Fifty patients hospitalized in the National Institute of Arthritis and Metabolic Diseases; (2) Twenty-four patients hospitalized in the National Cancer Institute.

Controls for each of the experimental groups were drawn from among current employees at the National Institutes of Health. Patients and controls were individually matched on six variables—sex, race, age, religion, education and occupational level. Approximate matching was also achieved on a 7th variable, viz. Social position as defined by Hollingshead.

In the analysis of the data the mean pathology scores of each matched group were compared, a detailed item analysis undertaken, and, finally, comparison of the scores obtained on highly focused clusters of items using the t test. It was found that:

(1) Mean pathology scores are generally but not significantly higher in the control than in the patient groups with nine exceptions which again are not statistically significant.

(2) Item analysis shows no significant differences holding across the board although a few reach the 0·05 level.

(3) In the cluster analysis the seven pathology scales developed fail to differentiate the controls from the patients groups studied.

(4) Only one cluster—Denial of illness (positive attitudes to the self)—differentiates controls from patients in both groups at a high level of significance ($P < 0.001$ in the arthritis study, $P < 0.01 > 0.001$ in the cancer study).

These data would appear to support the hypothesis that denial of illness arising from belief in the integrity of the self and the invulnerability of the body is associated with the maintenance of health.

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The pleasure and reality principles in group process teaching

By STEPHEN A. APPELBAUM*

The distinctions often drawn between education and psychotherapy, group and individual psychotherapy, and group psychotherapy and group dynamics are superficially plausible, and have been made to look even more so through institutionalization of them by disparate professions. Yet in important respects they are similar. All of them come about through learning and change in an interpersonal context. They have in common motivation, reward, and practice. They can all be measured, from moment to moment, as to how much attention is given to the process, how much to the content. Looked at in this way many of the differences seem to reside more in the goals of the teacher–leader–therapist (and his consequent techniques) and in the putative purposes prescribed by social and technical conventions than in intrinsic means by which the individual learns–changes–gets better.

As Freud put it, 'The contrast between individual psychology and social or group psychology, which at first glance may seem to be full of significance, loses a great deal of its sharpness when it is examined more closely.... In the individual's mental life someone else is invariably involved...and so from the very first individual psychology...is at the same time social psychology as well' (1921). In describing the teaching of psychotherapy Ekstein and Wallerstein write, '...both supervision and psychotherapy are interpersonal helping processes working with the same affective components, with the essential difference between them created by the difference in purpose' (1958). In comparing group psychotherapy and group dynamics 'training groups' Jerome Frank writes, '[they are] better viewed as points on a continuum than

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as differing in essence. Both are learning situations which have the aim of bringing about changes in their members' (1963).

Classes in group process, organized and taught as described below, provide a terrain in which education, group dynamics, and group and individual psychotherapy meet, without fixed borders. Such classes convene for the purpose of observing group phenomena as these are encouraged to develop in the class itself. It is assumed that some such phenomena are at least latent in all groups. But in groups constituted similarly to these classes, these phenomena become readily apparent. This is so because the absence of work (other than to observe the emergence and development of group process) makes conspicuous many aspects of small group dynamics which are usually masked behind rules of order, schedules of production, and highly directive leadership. As with projective tests and the encouragement of transference through limiting information about the therapist, the minimization of structure enables ordinarily latent behaviour to become manifest. Through attuning himself to the behaviour patterns and forces which he observes and experiences, the student develops a repertoire of phenomenological and inductive information with which to understand better his own and others' behaviour in a group, as well as the group's corporate behaviour.

Psychiatry has become interesting in these classes for at least two major reasons: (1) Attempts to understand psychopathology have led to ideas not only about the interpersonal origin of symptoms and behaviour difficulties, but to the notion that inadequate interpersonal functioning, or styles or negotiating, are in themselves conditions to be treated. Logically, a small group which is organized so as to present a continuous challenge to

social adaptation is a medium well suited for psychotherapy. Group psychotherapists can use the insights learned in training classes to make interpretative comments about group process, in addition to comments they may choose solely on the basis of knowledge of the individual. (2) Some psychiatrists, such as Berman, look upon group process classes as similar to psychological treatment, in that both provide opportunities to appreciate experientially data which would otherwise be known only in the abstract (1953). In Bertrand Russell's terms, as applied by Richfield to the problem of the nature of insight, the student gains knowledge by *acquaintance* in addition to knowledge by *description* (1954).

To the extent that the educational–dynamic –therapeutic processes are similar, and apply both to individuals and groups, it would seem profitable to examine these processes, as they ensue in training classes, with reference to a concept prominent in the psychoanalytic understanding of individual personality development. The concept chosen is Freud's pleasure and reality principles (1911).*

Under sway of the pleasure principle the individual is dominated by a striving for pleasure and withdrawal from pain. It should be added that the English rendering of *lustprinzip* as 'pleasure principle' erroneously implies that the object of the fundamental rule of mental functioning is simply 'pleasure'. Rather, what is meant here, in keeping with what I believe is Freud's original meaning, is the infantile striving for direct and immediate tension release, for taking the shortest distance between two points regardless of the consequences, for behaving under the premise that gratification should be immediate, exactly what is craved, and should involve work only to the extent of fantasying what is wanted. As the result of interpersonal and physical frustration of this tendency, the reality

principle develops: the individual learns to attend, remember, judge, delay, and think, and in other ways adapt himself to approximate as best he can under present circumstances the dictates of the pleasure principle.

This broad concept has, of course, many implications. But for heuristic purposes it is here applied narrowly to the life of a hypothetical group of people according to the following paradigm: wishes derived primarily from the pleasure principle—those saturated heavily with orality, passivity, and unreality—meet with frustration. Recognition of the reality of the group's situation follows upon the frustration and leads to the development of new means of satisfaction. A similar march of events may be observed in all treatment processes, often conceptualized as the repetition-compulsion, as the patient runs through a gamut of earlier modes of adaptation which are usually more infantile, passive, and inefficient for purposes of learning and change.

The group process classes as described in this paper are organized as follows:* Prospective members enroll themselves by agreeing to a verbal contract which specifies time and place of around twenty hour-and-one-half meetings, attendance requirements, the taking of minutes, possible work assignments, and the goal of studying the psychology of groups. They meet with a leader whose sole 'teaching' consists of helping them observe what happens under these conditions.†

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* For another explication of this method see Semrad & Arsenian (1951).

† In what follows licence has been taken, for purposes of exposition, to present schematically and impressionistically material condensed from a number of groups in the author's experience with psychotherapy groups and teaching groups, in the Menninger School of Psychiatry, Brockton and Boston V. A. Hospitals, Division of Legal Medicine of the Commonwealth of Massachusetts, and Boston University. This illustrative exercise hardly exhausts the many issues and events which occur or the meanings which can be attached to them.

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* R. L. Sutherland describes a parallel between infantile psychosexual development and the learning process in a school of psychiatry. He adds, 'But the same *motif* can be seen in any classroom or in the teaching of any new skill' (1951).

Surround any group of people by walls, face them with each other and themselves without a clear purpose or task on which to focus, and they become uncomfortable. They turn to the leader for help with their discomfort. He suggests that their first problem is to decide who the recorder of minutes is going to be. Sometimes they perform this task with dispatch by some system such as going in alphabetical order. This done, an uncomfortable silence again falls. Sometimes, with a glance over their shoulder waiting for the leader to step in with a solution, they make work for themselves by flailing away at what seems at times to be an insurmountable problem of deciding how recorders are to be designated. Or, sophisticated and controlled, they solve this and other problems and then join together in a show of camaraderie and unity to take issue with the contract; then the leader asks if they know each other's first names. The banding together is revealed as premature and artificial, and they look to the leader again to lessen the discomfort.

In other educational experiences—early years of life, school, learning special skills—a prominent attitude of the student, often promoted through lectures and rote-memory examinations, is to receive instruction, doing only what work is necessary to digest what is fed. Group members seek to re-instate these familiar and congenial attitudes. They wait expectantly, no matter how busy they may appear. Where are the answers they not only crave but deserve, for they are here, signed up, with tuition paid? Instead of answers they get a contract which makes demands upon them. Or so the contract seems to them, for no matter how non-demanding, how sensible, how like their own desires it is, they attack it. If it specifies punctuality, their wish is to be late; if it requires attendance, they wish to be absent; if it sets forth a particular distribution of minutes, other ways become attractive; if it includes projects or papers for them to do, they are rebellious. The wrong solid food of the contract and its demands is spit out.

'Sooner or later', as one member put it, 'you must give us milk.'

Another theme is sounded: 'If you won't teach us, at least you can help us with our problems.' A meeting falls on a holiday or a member is going to be out of town. Should we meet anyway? Maybe we can meet another day, in the morning, evening, dawn? Will the leader be there? Or, a persistently silent or truculent or disorganized or helpless member derails their discussion, or provides a screen for projections which make members uncomfortable. Somebody wants to bring a friend to a meeting, or a dog, to shut the blinds or refuse to take minutes. Though these are their problems, they turn to the leader for solutions, blandly disregarding the reality of their own capabilities in favour of hopes for an easy, pleasurable, being-taken-care-of solution.

They revert to another familiar attitude from earlier learning situations—currying favour with the leader. One member thinks: Surely the leader will like me best as I am the brightest one. Other members think: The others are so assertive, surely I'll be the favourite because I am the most tractable. They are treacherous, I am loyal; they are rebellious, I am easy to get along with; they misunderstand the leader, I am his interpreter. Each member wants to be the chosen one. Apparently talking to each other, they are using one another as vehicles to establish themselves with the leader. Notice how they look surreptitiously at the leader while they are ostensibly talking to other members. Under the sway of these wishes, communication at times become chaotic. They misunderstand each other, interrupt each other, forget what each one says. But wanting to be the favoured one with the leader is only half of the story; the other half is anger over persistent frustration by him, so the communication with him, verbally and through the minutes, is also marked by forgetfulness and misunderstanding. People are talking to and for themselves; their efforts, under a pall of disappointment and anxiety, are dispirited and confused.

If the leader will not relieve discomfort, teach them, solve problems for them, or love each one better than the other, then they will love each other. So pairs develop, mother–son, father–daughter, mother–daughter, father–son, brother–brother, brother–sister, each one a reversion to a past unity which now gives in fantasy promise of bringing about matters as they want them. Only the coin of these mergers fits with the present—sharing of smoking equipment, passing of notes, offering intellectual agreement and support. The leader systematically calls attention to these pairings with remarks that invite the members to bring the private exchanges into the common currency of the group. Members react, however, by feeling guilty at having cut off their fellows, and ashamed at the revelations of their liaisons. Though sometimes they hear the leader's remark as a welcome back to the larger group, more often it seems a rap on the knuckles.

This leader is really impossible. We are having a tough time, and it is his fault, so the least he can do is to relax the rules. With disappointment and rebellion they ask for licence to enjoy the forbidden.

But what is forbidden? The one set of rules, the contract, has been breached, but all the leader did was point that out; it was some fellow members who expressed outrage and became the enforcers. One action, however, seems increasingly forbidden in the minds of the members. This is independent decision or initiative. The leader says he must leave the next meeting early. Though they are angry at this 'rejection', and mournful at this loss, no one asks where he is going, nor does anyone bring up the possibility of meeting earlier or at another time. When their attention is called to this, they are amazed at the idea of acting with such temerity. 'You didn't say we could', they complain, 'how were we to know'? In the next breath, however, they talk boldly of plans for a variety of independent actions, countermanding in advance the leaders fancied objections. Yet amidst their protestations they hint, then ask for the leader's permission. They seem to have yielded their own capabilities for deciding on right and wrong in favour of a new repository of ethics, the leader; who, to still their guilt, must give some signal that they can be irresponsible as they once were.

The leader, as an agent of a reality which members know but find difficult to acknowledge, becomes in members' eyes an inciter and a spoil-sport. He helps them to observe their patterns of injured social sensibilities, overpoliteness, scholarliness, feigned indifference, and bluster; and he encourages them to see wishes associated with the pleasure principle embedded within these attitudes. At the same time he systematically disappoints these wishes. If he were to ease their discomfort, there would be no need for them to learn how to do so themselves. If he were to solve their problems, their latent skills would fail to emerge. If he were to distribute his affection unequally, all those less favoured would be weighted with an increased burden of resentment and disappointment toward the leader and other members. And the most favoured member would lock himself in place, learning nothing new, as he exploited only those assets which got him to his enviable position. Instead, the leader treats them all with scrupulous equality, encouraging the idea that he is a person who loves them all, equally well. '[Education] makes use of an offer of love as a reward from the educators; and it therefore fails if a spoilt child thinks it possesses that love in any case and cannot lose it whatever happens' (Freud, 1911).

Skins gleam with perspiration, faces redden, lips curl, bodies fidget or slouch. Then physiological discharge becomes channelled into organized patterns. A female, refusing to talk for hours, sits with her legs steadfastly apart, coolly draining off her discomfort through symbolic bodily behaviour. Male and female begin sitting together, or studiously avoiding each other. Seating arrangements are changed, food is brought, members come late or leave early as a rash of 'unavoidable' events develop, and news filters

back of paper work undone and sudden flare-ups with supervisors. But acting-out and acting-up meet with confrontation which aims to bring all events back into the arena of scrutiny, thus reminding them of the group's avowed purpose.

As this egocentric absorption continues to pay such small dividends, members more and more look for what can be done with the social reality around them. They are in a group of people, and carry within them a repertoire of emotionally charged experiences with groups. These begin with the family, extend through childhood gangs and adult professional organizations, achieve ethical stature in the ideal of the brotherhood of man, and often culminate in the fantasy of the children of God reunited in the Heavenly Hosts. So new in-groups hold promise of the satisfactions of the primary group. But an obstacle to the formation of new groups is that everyone continues to feel that others, not oneself, ought to yield. A compromise solution presents itself: If each can find something of himself in the other, they can make common cause without changing anything internally; in fact, each one's opinion of his 'rightness' is more confidently held as it is supported by others; each can go on pleased with himself as always, yet feel that he has achieved tolerant accord with his fellow men. So the group dissolves into boys versus girls, psychologists versus psychiatrists, those loyal to the group and those who question what all this 'groupiness' is about. Unlike the earlier pairing, the new units are larger, more complexly organized within themselves, and united by the common cause which is often buttressed by an intellectualized rationale. At war with non-selves, the several groups mill about, having made a step toward the reality principle of approximately the same magnitude as has been made between nations of the world.

The leader asks, 'How many groups are there now?' which serves to disrupt the new equilibrium. But then he goes on to help the group see that a similar process can be used to form one single, and more powerful, group. All that is necessary is one common cause, and that they all have, the problem of the leader, from whom nobody, and no groups of anybodys, can wring the satisfactions he wants. Individual attacks on him have occurred previously but have been dissipated through the fears of the attacker, or fended off by loyal lieutenants, or inveterate peacemakers. But now the group seems ready to push toward unification around their common problem. Like a clarion call a seemingly innocent quotation finds its way into the discussion: 'The bad that men do lives after them, the good is oft interred with their bones.' The leader asks the source of the quotation. The implications of a funeral oration over the body of the great leader, Caesar, brings anxious titters, but, in this together, they determinedly move ahead.

By turns the leader is criticized as cold, anxious, incompetent; too young or too old, too well-dressed or too informally dressed. When the leader picks up his contractual option of assigning work, there is a climactic and unified outpouring of anger at this unfair and demanding taskmaster. But a curious theme runs through these crashing chords. Notice how the subject of the leader's not appearing for a meeting comes into the discussion, and brings, not joy, but a sudden chill. Furtive eyes search elsewhere for the culprit, each one acting as if he is the one who has driven the leader away. A room full of Hamlets, they vacillate, the hollowness left by attempts at humour being filled with waspish snapping as the entente sags, becomes firm, then buckles again. It seems they want only to fight, but not to win. An *esprit de corpse*, as one recorder's slip of the pen illustrates it, seems not worth the price of guilt over the leader's symbolic murder. Not only is the band of parricidal brothers and sisters ashamed and guilty, but it seems they are looking past the leader's demise to what may lie in store for them. They have noticed how the strong, quick-witted 'assistant' leader fares. As his reward for interpreting the

leader's remarks, helping weaker members, cutting down the bully, the obstreperous, the fool, he is driven outside, an alternative for attacks on the leader, the next candidate for witch hunt and guillotine.

With disdain for consistency the group ceases in its disavowal of the leader's ability to give even bread, to discover they are getting cake. He may not be a teacher, but surely he is a psychotherapist. The goal of learning group dynamics seems far removed as a member blurts out his recognition that he acts towards the leader as he acts toward his father. In a rush of corroborative remarks about this 'gem', magic fills the air, and a surge of gratitude bubbles into locker room camaraderie. Rather than contend with the repercussions of ridding themselves of the leader, they install him as a wise, bountiful saviour. When he asks whether they think 'gems are a group's best friend', they are hurt and bewildered. But, though sullen and reluctant, they start again to flex their growing psychic muscles.

A piece of reality, hitherto overlooked, is discovered. They are able not only to make changes in defiance but with zest and exploration. Undeviating seating arrangements change, fluctuating ones become fixed, the colour of the paper on which minutes are typed becomes shocking orange, there is talk of altering the format of the minutes, and the traditionally silent recorder speaks. Members report they feel different toward the leader; he is less 'blanked out', more of a person. These strengthening exercises prepare them for the moment of truth when they are faced with making a major decision independent of the leader; let's say, to change a meeting time. To the extent that this decision is either a blustering rebellion or a sour alternative to the hope that the leader will step in and make it for them, they work fitfully, openly or covertly turning to the leader for acquiescence. To the extent that the decision is a response to the pull of present problems which requires present adaptive solutions, they make it independent of the leader. To the latter ex-

tent they achieve an emotional climax of satisfaction with a job well-done, of newness, and discovery. It is an achievement that stands them in good stead as yet a new piece of reality intrudes—they are approaching the end of the allotted life of the group.

Someone mentions the imminence of the group's ending. A heavy moment of silence ensues. A member adds he is going away and must miss the last meeting of the group. This time there is no talk of contract, injured feelings, or attack. Instead, long silences alternate with busy checking of dates and schedules. In trying to remember the originally stipulated number of meetings they accidentally add one more meeting to the total. And they recall the date of the last meeting as a week later than the one which appears on the calendar. They talk of extending the life of the group; if not with the leader then by themselves. As they leave the meeting they are bunched in solemn procession. The next meeting opens in a careening series of dialogues, witticisms bright and sharp which click through the air, hurried along by crackles of laughter. But as the tempo slows, then lurches, the leader asks what their feelings are, and the jerry-built denial collapses.

'Who needs him anyway?' is the theme as the leader is steadfastly ignored. Members move their chairs so that their back is turned toward him. He tries to speak, but someone always launches a comment before the leader can get under way. He asks, 'Does anyone besides me feel I am being left out?' Members turn back sheepishly, and in the ensuing discussion recognize they have tried to leave the leader rather than suffer the blow of his leaving them.

Sour grapes yields to a request for heartier fare. Discussion is organized around requests that, with the end in sight, the leader give up his accustomed role as a teacher of group process and give them something real such as a lecture on group process. Though earlier in the group's life they have systematically 'forgotten' the contract, the one piece of information directly given them, and though

they ignore the possibilities for learning in the work assignment of writing their own view of topics related to the group, they insist it is learning that they want.

Is it still the small child talking, asking for implicit approval through a reward, or for a magic word that will ease the tension and erase the problems in a twinkling? Is this request only another means of denying the ending? There may be some of all these possibilities in it, for the reality principle does not dethrone the pleasure principle but rather safeguards it. And what reality is not determined in part by unceasing influence from the past? But perhaps they want something of the leader to take away with them, less as a talisman of faith that they will be kept secure than as an investment in themselves. This is what they say. They want a lecture and discussion in order to become better group therapists. They want to learn the meanings of material over which they have puzzled. They want to check their own impressions against those of the leader. They want to take his bag of tricks as their own. And they must somehow be right in this because their fellows feel the same way. They know this because they have learned to listen and hear each other, and, give or take some differences, they really are not bad fellows after all, and often have useful ideas. Further, they have a right to this information: for the leader is one of them, and they feel a claim on one another.

But if they want mastery over the present, using the tools available from the present, and want to avoid the loss of the leader by being like him, the leader's work is already mostly done. By taking him away as part of themselves, they have become stronger antagonists to loss and frustration. They have taken the best there was to be had, and, in the process, have learned much of what there was to learn.

Is this education or is it therapy? As an educational device, the group was encouraged to develop its adaptive functions in order to gain mastery (shift reliance from the pleasure principle to the reality principle) and to observe how, under these conditions, this happens. 'Education can be described without more ado as an incitement to the conquest of the pleasure principle, and to its replacement by the reality principle...' (Freud, 1911). This, too, is a means by which therapy proceeds. The distinctions are more meaningful, it seems to me, in regard to goals, techniques, and the relative amount of emphasis paid to content and process. The principles are the same.

SUMMARY

Group process training classes have become of interest to psychiatry for the insights they offer to group psychotherapists, and for the opportunity they provide for all clinicians to learn experientially data otherwise available only in the abstract. These classes provide a terrain in which group and individual psychotherapy, group dynamics, and education meet without fixed borders. Despite manifest differences, institutionalized by disparate professions, a developmental process is assumed to be intrinsic to all of these disciplines, a process which can profitably be understood by the same means one understands individual psychological development. An attempt is made to view a series of trial adaptations of students in a course in group process training from the standpoint of Freud's pleasure and reality principles.

ACKNOWLEDGEMENTS

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On being ill in a mental hospital

By S. T. HAYWARD*

During recent years the number of patients treated in mental hospitals has increased: this increase is largely composed of those who formerly would not have gone into a mental hospital at all. Much has been done, and is still being done, for a great variety of cases by early treatment. However, there remain many patients whose stay in mental hospitals is of indefinite duration. There appears to be little evidence that modern forms of treatment have diminished the number of these patients to any appreciable extent.

In the hospital where I work I am responsible for 830 male patients, of whom about 575 are long-stay patients. Of these 425 are what used to be called 'Chronic Deteriorated Schizophrenics'. The problem presented by these patients who just go on being ill has received a great deal of attention and interest in recent years. It is with this problem that I am concerned in this paper.

It has been rightly said that one of our main difficulties in the assessment of this problem is that we know but little of the natural history of schizophrenia. On the whole our thinking in this respect is dominated by Kraepelinian and Bleulerian concepts. However, in this modern era in psychiatry, I think one must first of all express doubts as to whether this is a valid approach, for the simple reason that schizophrenia, like other mental illnesses, does not exist in isolation. It exists in relationship to an environment, human and material, and therefore it seems inevitable that the course of the illness must vary in response to these factors. It has always been recognized that the natural history of schizophrenia differs according to whether cases are under permanent care in a mental hospital or in permanent care in home

surroundings. It has never been known to what extent this is due to differences in the schizophrenia or in the treatment received. It has also been recognized that there is a somewhat different natural history of schizophrenia nursed in a public mental hospital, and schizophrenia nursed in a private mental hospital, where money is no object.

As long as schizophrenia was believed to be an illness in which a large proportion of patients tended to deteriorate in habits and behaviour, and to become wet, dirty, destructive and untidy, it was inevitable that this belief, both in the general public and in the medical and nursing staff, was reflected on to the schizophrenic patient, thereby tending to create in the patient those very symptoms which others merely believed to exist. Thus, in the past, in mental hospitals, when large numbers of dirty, wet, destructive and untidy patients were present, I have many times heard the statement: 'It is no good giving these people decent surroundings; it is no good giving these people anything worth having, because they are below appreciating it.' Therefore I think one may say that in the past our attitude, whether explicit or implicit, has been that most schizophrenic patients are bound to deteriorate, and that therefore we will look after them in surroundings which are extremely deteriorated in every way. The patients were considered the lowest of the low, the nurses who looked after them were only just one step removed from this lowness, and the doctors on the next level were throwouts and failures in medicine.

In an attempt to look at schizophrenia objectively, the most obvious and striking thing is the absence of an ego: there is lack of integration of the various impulses, affects and activities of the patient. One of the things that a hospital does is automatically to take over

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from the patient his ego-activities on his be-
half. In schizophrenia this event is one of the
most characteristic features of the illness. The
hospital provides an auxiliary ego for the
patient, with which the patient can live and
survive. It follows that the essence of treat-
ment must lie in our efforts to help the patient
to recover his own ego functions, instead of
being dependent on the auxiliary ego provided
by the hospital. However, this period, during
which the environment as it were loans ego
function to the patient, may be exceedingly
important for the patient before he can return
to a state of integration.

These observations of schizophrenic behavi-
our have long been known and discussed.
Bleuler pointed out how easy it is to institu-
tionalize schizophrenics, and how dependent
schizophrenics become in an institution.
Others have remarked how suggestible schizo-
phrenics are. But I myself think that the more
precise concepts of ego surrender, auxiliary
ego and ego loan are much more helpful, for
if we face these concepts, we come to recog-
nize that the most important view of treat-
ment of schizophrenia in a mental hospital is
that of returning ego activities to the patient,
those ego activities which he surrendered to
the hospital and which the hospital actively
took over. There has been much talk recently
of the process of institutionalization, and of
its unsatisfactory, indeed dreadful, results.
However, the process of institutionalization
has always been talked about as if it were
bound to be bad. I think it would be much
better if we could recognize instead that there
are bad forms of institutionalization and good
forms of institutionalization. Bad forms in
our past outlook are those forms in which the
patient has totally surrendered his ego to the
hospital: the hospital has taken over by pro-
viding an auxiliary ego, and has not allowed
any return back to the patient, either in a
therapeutic way by loaning ego function or
even by allowing such ego activity as the
patient positively wishes to exert. This is of
course what has happened in very rigid ward
atmospheres where there is no freedom. By

contrast, in the light of these new concepts,
the patient is able to leave hospital when we
have been able to allow him to have his own
ego back again. The patient who can only live
in hospital but is reasonably well there is the
patient who remains dependent on an auxili-
ary ego, that is on the hospital. So our job is
always to find out how to help the patient to
have his own ego back again.

Perhaps we should consider for a moment
the factors that cause a patient to be admitted
to hospital. In schizophrenia the onset of the
illness is heralded by the incapacity of the
patient's ego to manage his life. Various dis-
tress signals are put out for certain of his ego
activities to be taken over by his environment,
and such signals are issued frequently. Some-
times the family is able to respond to these
signals by taking over the ego activities of the
patient. But sometimes it is quite impossible
for the family to do this and so the patient
must be admitted to hospital. The hospital
then acts as an auxiliary ego for the patient,
and his discharge from hospital will be deter-
mined by the extent to which he can recover
his own functioning ego. 'Ego loan therapy'
is a continuous technique, and our most valu-
able aid in helping the patient to get his own
ego and ego function back. Perhaps I can
make this concept of 'ego loan' clearer if I
take an example from the physical field, for
instance, the patient who is recovering from
some debilitating illness characterized by great
muscle weakness. In severe stages of the ill-
ness the whole problem of mobility may have
to be surrendered by the patient to the en-
vironment, and the nurses and physiothera-
pists move the patient's limbs. As the patient
begins to gain power he is then helped by
someone else to move his limbs; and during
re-education in walking he will use the
strength of the nurse or the physiotherapist to
help him to begin walking again. He will have
been loaned the muscular strength of the nurse
or physiotherapist, and by the use of this
loan he is gradually able to recover his own
muscular strength and thus to do without the
loan.

I think it is important here to state that these concepts can be of value whatever theory we hold about the ultimate aetiology of schizophrenia. We must recognize that the ultimate aetiology is still unknown, and each psychiatrist must decide for himself whether he considers schizophrenia to be primarily an organic illness of the brain of an unknown nature, with mental symptoms, or primarily a mental illness due to defects in the emotional development of the individual. Many psychiatrists remain undecided in their view about the aetiology of schizophrenia; but from the point of view of a treatment programme this uncertainty does not matter.

However, to many psychiatrists who believe schizophrenia to be an organic illness of an unknown nature with mental symptoms, the immediate treatment problems become unimportant, and it is held that these must wait until research discovers the aetiology of the illness and therefore the treatment; in the meantime the patients are left to rot. The psychological school, on the other hand, if adopted by an individual psychiatrist, tends to put an intolerable burden on this doctor, which is difficult to bear, since he immediately feels he ought to be doing something about the illness. I think the result in each case is apt to be rejection of the patient. It follows that usually in mental hospitals a variety of events begin to happen: once the diagnosis of schizophrenia has been reached, the patient is rejected as an individual by the doctor, and sent over to the insulin ward as just another schizophrenic, where he receives the ritualized dose of 45 insulin comas. At the end of this time he is either fit for discharge or fit for ultimate chronicity in the hospital.

A long-term technique has never been worked out for the treatment and care of this type of patient. Doctors have had nothing to do with it, apart from treatment of intercurrent physical illness and from the negative action of trying to prevent the patient from being ill-treated, i.e. beaten up. The nurses have been left alone with the problem ever since the beginning of psychiatry and the beginning of the mental hospital. They have grown up alone with it: they have had the responsibility of management and custodial care of these long-stay patients. Thus there has been handed on a tradition of management and care within each mental hospital ward, from nurse to nurse, through the years, a tradition undirected, not understood, and usually completely outside the field of interest of the doctor. Hence, of course, it is just as true to speak of the neglected nurse as of the neglected patient. The old system can be easily described: there was the Medical Superintendent, whose adjustment was orientated to the management committee and to the demands of the outside world; the medical officers, who were looking upwards and adjusting to the medical superintendent's demands; the nurses who were looking upwards and adjusting to the doctor's demands, while frequently having to use an infinite number of defensive measures to prevent any inquiring doctor from knowing what was going on. The doctors were there to get the nurses into trouble, and this led to endless evasive tactics on the part of the nurses. At the bottom end was the patient, whose sole function was to adjust to the nurses.

But the new attitude I am trying to define consists of everyone looking outwards at the patient, the doctors, the nurses, and all others concerned: that is, everyone concerned with 'loaning' ego to the patient, with which the patient can support himself, and further, everyone 'loaning' a coherent ego to the patient. This last matter is of exceptional importance, especially in a shift system. There is no surer way of creating chaos than by having one charge nurse on one shift loaning one type of ego to the patient, and another charge nurse on another shift loaning an entirely different type of ego. Therefore the most important feature of treatment of long-term schizophrenia is that everyone in the hospital holds the same attitude to the patient, and therefore 'loans' him the same type of ego.

I think one of our greatest problems in psychiatry is that so far we have only one treatment method whereby doctors can continue to be interested in working with their patients indefinitely, namely, psychoanalysis. The presenting need in schizophrenia is for a body of theory and technique whereby we can show that a patient is having continuous treatment until such time as he chooses or does not choose to get well. The form of treatment must be such that the interest and enthusiasm of the staff is for the welfare of the patient, but the staff must not continually seek recognition from the patient in terms of the patient's recovery. The patient's recovery should be considered only as a pleasant side issue that sometimes happens, rather than something consciously and deliberately intended. The treatment used in a mental hospital must be such that a variety of people can continue to be interested in, and enthusiastic about a patient for an indefinite period. It is only in this setting that the quality and quantity of remissions of schizophrenics can increase, and it is also only in this setting that remissions can be fully used.

I will now try briefly to enlarge on this theoretical standpoint by illustrating the approach in practice: over an indefinite period of time we must continue to work towards the patient acquiring as much ego as he can tolerate, and towards ensuring that the auxiliary ego provided by the hospital is as small as possible. For a new case in an admission ward this process happens continuously. Take the simple example of a patient who has surrendered to his environment his ability to eat: the nurse feeds the patient: in other words a patient auxiliary ego is provided, the patient having surrendered his own ego function in this respect to the hospital. The nurse continually strives to help the patient to take this back again. That is to say, the nurse persistently attempts to help the patient to feed himself. Thus, throughout the patient's stay in hospital there should be this continuous drive to help the patient to take his own ego activities back.

REDUCTION OF FEAR

I want now to try to discuss some of the factors which can assist or hinder the patient in taking his own ego activities back in this way. One of the most important obstructive factors is fear. When I first started psychiatry, the existence of fear in patients was one of the features denied in mental hospitals, just as in the paediatric departments of general hospitals it was denied that children suffered in any way from separation from their mothers, and just as it has been likewise denied that children at boarding school are ever unhappy. Fear was in fact at one time a very important feature in mental hospitals, and sometimes still is. The whole method of management must be directed towards the reduction of fear, bearing particularly in mind that there is a close relationship, in the long stay patient, between fear and violence, and that much violence essentially serves to conceal fear. Fear can be felt on both sides, by patient and by nurse, and so can violent impulses. The best approach to the problem of fear can be described as encouraging the nurse to get to know the patient as an individual, e.g. friendly recognition of the patient's idiosyncrasies; the small objects the patient likes to possess and cherish. The nurse should and perhaps even encourage the patient to be on Christian name terms with him, which was a heinous offence in the past. Frightening things, such as jangling keys, padded cells, locked doors and barbed wire entanglements should be removed. The use of seclusion, and such methods as threats of dire punishment for disobedience, should be absolutely forbidden.

I think that for schizophrenics the abolition of enemas is unusually important. Such dreadful events as 'Enema Friday' may possibly occur no longer, but enemas are very frightening to most withdrawn schizophrenics, and they should never be given except to patients with whom a bond of total cooperation has been formed, and then only after discussing the procedure with the patient. Also the use of unmodified E.C.T. may some-

times fall into this category, and may be dangerous by thus leading to mutual fear between nurse and patient.

Self-help Campaign

Secondly, in this discussion of practical measures, I will speak about the encouragement of self-help in the patient. One of the manifestations of this in the hospital where I work has been the provision of opportunity for patients to make some of their own necessities: for instance, they may maintain and paint their own beds; and, most important, the patients have succeeded in building their own occupational therapy department. Attempts should be made to help the nursing staff to understand that their job is to help the patient to help himself. Unfortunately it was over this point that the mental hospitals lost much ground some 20–30 years ago, by the introduction of general trained nurses into mental hospitals. For the whole of the general training is orientated round didactic methods of dealing with the patient, and round authoritative ways of looking after the patient. This development undoubtedly had a bad influence from which we must get away; and we cannot say too often that it is the nurses' job to help the patient to help himself, that is, to help the patient to take a more realistic attitude to work within the hospital, and to the clothes he wears, the food he eats and likewise to the way he does these things. This self-help campaign for patients has many repercussions throughout the hospital, and it should of course be directed towards all aspects of work and its purpose.

Preservation of Working Habits

The next practical aim is towards the preservation of patients' working habits, or else towards the creation of working habits where these did not previously exist. It is natural for man to work, it is part of his life, and work, therefore, must be a fundamental part of treatment for a long stay patient. This work needs to be purposeful in nature, and to have a meaning which is obvious to the patient. It is from this point of view that I regard it as extremely important that patients should be employed in all aspects of hospital life, and that they should take part in the running and preservation of their hospital. This is one of the means whereby the patient may be allowed to feel that the hospital is intended for him. Thus, the more that patients can penetrate into every sphere of hospital life, the better. It is important, however, in this process that the right attitude should be shown to patients in terms of our words 'right ego-loan therapy', namely, it must be clear to all that the job is there for the benefit of the patient, and never that the patient is there for the benefit of the job.

With regard to work as a whole, our experience has shown that if a nurse is found who wants to do a certain job, and if that job can be made available, then there will always be patients who want to help that nurse to do that job. It is probable to begin with that many patients cannot derive any enjoyment or satisfaction out of doing the job. It is only through the nurse who leads the group and who wants to do the job being himself pleased and satisfied with the work the patients have done, that he can convey that pleasure and satisfaction to the patient in a way that the patient can feel it himself. This satisfaction may be only temporary in the patient to begin with, but later it becomes more complete and lasting and, as it were, his own possession. The patient probably always has to get it first from the nurse. I do not think one can overstress the therapeutic importance of the patient's wish to please the nurse. The more that fear is diminished and the atmosphere of homeliness and friendliness created around the patients correspondingly expands, the more often this wish arises. And it is so frequently the raw material out of which the treatment by 'ego loan' may be built. The reverse is of course also true and certainly such negative factors were highly significant in the past in bringing about the deterioration of numberless patients,

since by their withdrawal such patients were frequently not only pleasing a different type of nurse, but were also pleasing many other people as well by conforming to the current phantasy of the nature of mental illness. In the past, such rules as patients not being able to talk at mealtimes or to talk in the dayroom, being told to sit still and to be quiet, were common. Many patients adopted statuesque positions in the wards, as it appeared to them that this was what was demanded of them. Here it may be said how important are the hobbies and outside interests of the nursing staff, and how important it is for them to be allowed to bring these hobbies and interests on duty with them, not only in order to talk about them with the patients in their care, but also if possible in order to cultivate them with their patients while on duty, since in this situation there will always be patients who will want to help such nurses. How badly we need people with various types of craftsmen's skill to be with our patients and to know them sufficiently well, so that the patients will gradually want to please such craftsmen by helping them with their work and will thereby slowly acquire the skills themselves.

HOMELY ATMOSPHERE IN THE WARDS

It is important that certain activities are allowed to take place in something akin to a family situation, and I think it is a useful concept to regard the ward as a family situation, even though the members of the family are of one sex. Much of value takes place during the family meal situation, and the family bathing situation. Much emotional interplay on a verbal and pre-verbal level happens between the patients and staff in these situations, which has a direct effect in helping the return of ego activity. I would therefore always be opposed to any long-stay patient being in a large communal situation where feeding, bathing and sleeping are concerned, if this could possibly be avoided.

Together with this home-building attitude goes the re-painting of the wards in a pleasant way, the provision of domestic furniture, the continual effort to escape from drabness and to make in the ward a bright/hearty and friendly atmosphere, in which a variety of social and other activities can take place.

PRESERVATION OF GOOD CONTACT WITH THE OUTSIDE WORLD

It is essential throughout the whole stay of the patient in hospital that every effort be made to preserve his outside ties. This is done to begin with by encouraging visits by all the family and friends at times convenient to themselves. Later, whenever possible, the patient should have regular breaks at home, particularly at week-ends. The recognition that there is no such being as a patient who is too disturbed to be visited, and the encouragement of a friendly attitude between the nursing staff and visitors, are of the utmost importance. Charge nurses should be encouraged to discuss outstanding problems with visitors. All possible means should be used to gain the help of the relatives. It is here, of course, that the psychiatric social worker's department is of great importance. This department is responsible both for gaining and preserving the co-operation of relatives with what we try to do for the patient here, and also for providing such social or environmental therapy as may be needed from time to time by the outside world in as far as it impinges on the patient. These links, if preserved, can make all the difference in effecting the patient's discharge, and in ensuring his satisfactory adjustment to the outside world, particularly if his improvement has happened only after a long stay in hospital. It is important that the patient should always be present at family gatherings; and when we have reason to think that a patient is going to be with us for a long time, we make it clear to the relatives that we always wish the patient to be present at any family gatherings of importance, such as funerals, weddings, engagement parties, etc. If at the time these happen the patient is then in rather an ill phase, we are willing to supply a nurse

to go with the patient to the wedding or funeral, or whatever the event is. All support must be given to the relatives, so that the patient is never forgotten in family activities; and the psychiatric social worker also must try to deal with the automatic tendency in some families to close up, reject and excrete the patient, as if all the bits of lunacy in the family were squeezed into the patient and thereby excreted into a mental hospital. We must encourage our psychiatric social workers to see that all the relatives of the patient keep their own bits of madness, and that they become more aware that the hospital is for the patient, a place in which the patient can live and can be helped to become a person again, rather than a cloaca for unwanted community and family problems.

DOCTORS

With regard to doctors, we have been discussing for years the professional difficulties of doctors in their work, and the problems created by the various defensive and evasive tactics which doctors have to carry out in order to support themselves. Here it may be relevant to say a few words about drugs. Drugs can only be ordered by doctors, and therefore they can be used by doctors for many different purposes. Certainly they are used both in order to preserve the doctor's self-respect and omnipotence, and also in order to relieve him of his anxiety over his apparent inability to do anything for the patient. They are regularly used to placate the patient, which probably does not matter provided the motive is plain. What is much more important is that they are often used to restrict the means of communication between the doctor and patient. It seems to me that doctors, through the practice of years, have entered into collusion with the nurses and patients over the question of drugs. There has always been the problem that there is not enough doctor-time available to the patient, so drugs have been given instead. This of course emphasizes the traditional importance of the doctor, since only the doctor can order drugs.

It seems important to acknowledge that in a setting of continuous treatment the doctor is helping the nurse in his efforts to enable the patient to accept his own ego again. The nurse will frequently wish to discuss the problems that arise between himself and the patient with the doctor, and both are working towards understanding the patient, the doctor in his directive role and the nurse with his more immediate and continuous contact. I think that the doctor must be sufficiently good, sufficiently supportive, sufficiently anxiety-absorbent, in effect to be with the nurse in all the nurse does throughout the 24 hours. In other words, to use an American concept, during a 24-hour day, when the nurse is left to look after the patient, the doctor must be effectively with and in the nurse, even when the nurse is left without the doctor. (When the nurse is left to look after the patient without the doctor's presence, the nurse must feel as if nevertheless the doctor were working with and through him.) It is only when such processes of communication are worked out in a harmonious inter-relationship that a constant helpful 'ego-loan' to the patient can take place. Indeed, it seems to me that, to use an old and undesirable word, the doctors are largely responsible for achieving the chronicity of their patients, because of their constant and overpowering need to do something active, to be omnipotent, to cure their patients. This difficulty in doctors of an overpowering need to cure their patients has, of course, met with endless disappointments and frustrations in psychiatry, and has led to repeated rejections of patients, as well as to continuous neglect of those who nurse the lost patient. It is not until doctors can sit down and be content to do nothing that they will be able to do anything at all. It is not until they can sit down side by side with their patients, without a massive protective desk between them, that they will be near to their patients and with their patients. It is not until they can allow themselves to be at ease and patient with their patients' illnesses, that they will be able to help the patients to be patient with their own

illnesses, thus helping the patients to feel that somebody is with them and supporting them in being patient with their illnesses. We must always remember that although it may be a good thing for a hospital to be a place in which patients can get well, it is equally necessary and important for a hospital to be a place in which patients are allowed to be ill. Many patients in a hospital in which they are expected to get well will experience the efforts of the doctors and nurses to cure them as a form of punishment; and there are only a small group of people who are able to have the illness punished out of them. Most people respond to attempts to punish illness out of them by becoming worse; therefore we must have doctors who can allow patients to be ill, for it is only by doing this that the doctors can supply the 'ego-loan' which will help the patients to get well.

One of the most striking results of our present system is the frequency with which diverse numbers of patients use the chief male nurse and his deputies' offices as a consulting room, to which they bring their complaints and grievances; they use this opportunity to let off a lot of hot air generally, and then they go back happily to their wards. Occasionally, of course, they also use it to express their praise of the hospital.

It is hoped that when these various concepts have been fully transformed into action, then at last a situation will exist in which consistently useful work can be done (or 'a situation will at last exist which provides the best conditions for therapy').

I look forward to the time in the future when with my 425 schizophrenic patients I can say that all of them are in a continuous treatment situation, and that in each individual case there is some aspect of their lives with which some nurse or some person is pleased and proud. The achievement may be small, such as the ability to control the bladder, the ability to brush one's hair, or to tie one's tie; or the achievement may be big in some creative way. I would like to see reformulated a view of schizophrenia in which

this illness sometimes on the one hand runs an acute course, that is to say, the patient gets well reasonably quickly in the matter of a few months, and after this length of time he is able to take his own ego activity back again with the minimum amount of help; but sometimes on the other hand the illness may last a long time. There are many patients who are unable to get well quickly, or who for reasons which we do not understand at all do not choose to get well quickly. We must therefore have a treatment programme that continues indefinitely until such time as the patient chooses to live without it by getting well. One of the main constituents of this treatment therapy will be 'ego loan', since this must be the most important technique by which we can help our patients to receive their own ego activities back again. With such a treatment programme in process our remission rate from schizophrenia will increase, and we shall have a large number of patients who will recover after several years of the illness. But our treatment programme must go farther than that, and must be such as to be prolonged indefinitely for the rest of the patient's life, if the patient is unable to decide ever to get well. Public attitudes, medical attitudes and wrong orientation to treatment must all be regarded as some of the most important factors causing the chronicity of schizophrenia, rather than as the accepted view of the history of the illness. The natural history of this illness is quite clearly towards recovery. The length of time required for this recovery varies considerably from case to case and the quality of the recovery as well as the length of time required must vary very considerably according to the kind of treatment situation in which the patient is placed, and also according to the attitude of the hospital towards ego surrender, auxiliary ego and 'ego loan'.

I would like to finish by saying that our management and treatment of schizophrenia, our future knowledge of this disease, its symptomatology and duration will all depend on our intensive study both of the ego activities which the patient surrenders to his en-

vironment and also of the nature of the auxiliary ego which the hospital, the doctors, nurses and sometimes the family, provide for the patient when taking over his ego activities. We must also study the factors which enable the patient to receive his own ego activities back again, as well as from the treatment point of view, those factors which may enable us, as doctors, to help the patient to take back his own ego activities. The most important of these factors must, I think be 'ego loan' therapy. It is only when we can think along these lines, and when much more research work is done in this direction, that those who are called schizophrenics can become people and individuals in their own right once again. It is possible that this programme cannot be undertaken by nurses and doctors alone in hospitals, since it may well be that these aspects of schizophrenia have important repercussions throughout the society in which we live, and therefore we as doctors may find that we are more dependent for our activities than we realize on the present attitudes of society.

Observations on some defensive aspects of delusion formation

By JAMES M. DAVIE*

This paper consists of an account of some observations drawn from the psychotherapy of a 23-year-old female schizophrenic patient. She first fell ill early in March 1958, and after a suicidal attempt was admitted to the psychiatric wards of a general hospital. At that time she displayed some hysterical traits alongside a depression of mood. On this account she was given a long course of E.C.T. The depression lifted but because of the personality difficulties she was referred to a Clinic for out-patient psychotherapy. Within a few weeks her violence at home became so alarming that she had to be admitted to mental hospital.

She gradually settled under a régime of superficial psychotherapy and chlorpromazine. She was discharged from hospital in April 1959, but was regarded as a diagnostic puzzle. There was general agreement about the hysterical personality disorder but less conclusive evidence of a manic-depressive trend. No evidence of schizophrenia was reported.

Following a few months at home she attempted a return to her work as student nurse, but after a week in the ward was re-admitted to mental hospital in October 1959. The treatment which consisted of chlorpromazine and E.C.T. was without effect. By now there was unequivocal evidence of thought disorder, incongruity of affect and hallucinations. The patient clearly suffered from a schizophrenic illness. It was at this stage, early in January 1960, that the investigation of this patient was begun. The setting is a forty-minute face-to-face interview at regular times, four sessions per week. The observations cover a period from January 1960 until May 1962. They roughly fall into two categories—psychotic

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and neurotic. Particular attention has been paid to transference manifestations because of their value for the understanding of non-psychotic processes and because they can reflect aspects of pre-psychotic development. Further, the distortions of the transference which occurs can help in elucidating the relationship between neurotic conflicts and psychotic phenomena.

The initial psychotic phase gave way after 3 months to a neurotic period which lasted about 14 months. The second psychotic phase lasted 7 months and this was followed by a remission of 3 months. During her remissions the patient lived at home and attended as an out-patient. During the long remission in the first year a classical analytical technique was used instead of the face-to-face interview. Her behaviour in this non-psychotic phase made it clear why there had been such apparent confusion about the diagnosis. Depending on the predominant defences she was depressed, hypomanic, bizarre in her behaviour or at times apparently normal.

When therapy was commenced in January 1960, the patient manifested thought disorder, delusions, perceptual distortions, visual and auditory hallucinations. This can be referred to as *psychotic phase* 1. Gradually these phenomena died down giving way to the first neurotic phase.

NEUROTIC PHASE I

The most striking initial manifestations resulted from a sexualization of the transference. Her material indicated that this sexualization had a defensive function. She resented the role of patient and the passivity which it implied. Hatred and envy of the therapist was hidden behind the sexualization

of the treatment situation. The resultant behaviour (acting out in the transference) could easily have been mistaken for hypo-mania. She was constantly dashing all over the place, never at rest and always with some young male patient in tow. From her associations it appeared that this had been her behaviour in her hospital just prior to the initial breakdown. She had felt uneasy about being different from the other girls. She had hardly ever menstruated. Almost consciously she threw herself at the available medical students and was for ever having crushes on the housemen.

She would openly confess her love of the therapist. This was interpreted as the result of her defence against fear and envy of the therapist's potency and basically of his penis. She revealed that she had in fact been very restricted with the boy friends. On occasions she had taken the precaution of wearing a tight-fitting swimming costume underneath her clothing. She described her fury at first seeing an erection and her terror of the gynaecological examination which followed her complaint of amenorrhoea. It is this experience which appeared to be the immediate precipitating factor of her illness.

The transference then moved towards her father. Apart from a short, brief period when she was three, he had been in the Far East until she was five. Until then she had slept with her mother. She first re-experienced the relationship with father in the transference. It was expressed in a period of violence with the occasional chair or ash-tray flung across the room. There was also an instance of mild wrist slashing. Each of these incidents was always followed by an apology, perhaps even a week later. After working through this in the transference she began to remember just how much she hated her father, how he beat her with a strap and how at times she would even taunt him to do this. These current rages with the therapist were interspersed with phases of depression when she would insist that she was not real like other girls, that her basic blue-print had been left out.

Her father died of carcinoma when she was 12, suffering much pain in his last few months. Recollection of his death, however, evoked no grief reaction, only bewilderment at his crying with pain and concern at her mother's upset. She remarked on her mother's surprise at her lack of tears even at his funeral. Her depressed feelings and the sense of being different could now be understood in part as a guilt reaction to her death wishes. Ventilation of these guilt feelings then led to the expression of grief at his death and to memories of their happier times together; how he used to play the piano and sing, how young and handsome he had been on returning home from the Far East. These memories helped to show her why she was so often attracted to coloured men and would experience vaginal sensations whenever she heard coloured singers of either sex.

There was by then a marked change in her behaviour both in the sessions and outside. Her intrusiveness and talkativeness were now replaced by avoidance of contact with others and reticence. There were long periods of silence. Upon entering and leaving the consulting room she had to avoid looking at the therapist. She feared lest she would be swamped by loving or hating feelings. She found it easier to hate than love—it was less painful. In fact she tried to avoid feelings altogether. She gradually reported how these feelings could be triggered off outside just by noticing people, men or women, boys or girls. She feared that she might merge with the other person. This latter reaction was in fact much stronger and overwhelming in her psychotic phases.

She defended herself against anxiety by marked restriction of her activities. Necessary contact with others was terrifying. Travelling to her session in the tube was possible only by hiding behind a book or knitting. At times she even travelled a very long way round by ferry and at other times would walk rather than go by bus just to avoid contact. She gave up visiting cinema, church, and even friends. She tried desperately to deny feelings for the therapist. Conflict was always present. She

found it difficult to differentiate between love and hate and whichever it was, it threatened to engulf her—as she put it 'I am always all love or all hate, there's nothing of me left at all'.

Her reaction to separation is illustrated in the following example. She envied the therapist his freedom to go away to some interesting place while she was merely going to a local seaside resort. She remembered that she had been in hospital at the age of 7 with scarletina and how miserable she had been. She recalled trying to comfort herself by masturbating, just as she found it necessary now before going to sleep. A few days later she reported a dream in which she was hugging her father round his waist and he fed her porridge, that her face was where his nipples were and he was telling her that as a little girl her mother had loved her very much.

Associations to the dream reminded her of sex play with her sister who is three years older. They had slept together after her father's return. She used to masturbate while fondling and sometimes sucking her sister's breasts. She remembered too feeling envious on noting her sister's physical development and insisting that her breasts would grow too. This reminded her of an incident when she was three or four when she had made the same retort to a small boy while watching him urinate. Her next association was to an old phantasy she had had of men with breasts.

The common element in these phantasies was the equation of breast and penis and her envy and hatred. The extent of her anxieties—of genital damage (castration anxiety) and separation anxiety was proportional to that hatred, now re-awakened in relation to the therapist. In the dream, however, there was no manifest hatred at all—mother had loved her and father gave her what she wanted. The analysis of this transference dream enabled the therapist to show the patient her dread of her hatred and envy. The dream also showed that she introjected the penis which was unconsciously equated with father and therapist as a defence against castration anxiety.

The theme of bisexuality then predominated and with it over the next few months a feeling of falseness—of being different. She spoke of her fears when she had shared rooms with other girls and how she would then fly to boys but mostly how the usual talk of dates and love affairs left her bewildered and puzzled. She then realized that to some extent she had merely been acting a part as if she were like the others rather than truly feeling identified with them. These reactions also appeared in the transference when she felt guilty about keeping a date with the therapist, not revealing her true self—her true feelings. At one session she heard the therapist moving. She became very anxious feeling sure that he was masturbating. She associated to the incident with the young man who had tried to interest her in his penis and to whom she had reacted so violently. Further questioning, however, revealed her own masturbation from the previous night. An interpretation of her identification with the therapist uncovered phantasies of possession of the penis and of penetrating two of the senior nursing staff who represented her mother and sister.

The masturbatory guilt could now be understood as the central nucleus of her false feelings. Although conscious of her homosexuality further guilt arose from the phantasy of stealing the father's penis and this was equated unconsciously with killing him. The absence of menstruation was felt as proof that she had damaged (castrated) herself.

Positive feelings for the father emerged again with phantasies of oral impregnation. Associations led to memories of kissing boys—of father who had been so kind and gentle when he removed one of her baby teeth and had given her sixpence. Smoking now made her sick, especially the thought of the therapist's cigarettes which in her first psychotic phase she had frequently demanded.

A dream fragment was reported in which a mechanical crane was operating in her mouth and from it a rubber tube which curled up inside. She had attended the dentist on the previous day for a special gold filling and as

usual felt very frightened and sick. The catheter reminded her of the ones used in gynaecology and its being curled up like the foetus and of the baby her mother had lost. She recalled that the child, a boy, had lived a few days. She had been sent away to her grandparents and had been very sick, hardly able to eat anything without vomiting. It was realized too that her earlier assertion of being in hospital at the age of seven was wrong. In fact it was at the age of five. The aim of this dream was similar to the one reported above. On this occasion however the envy and hatred related to the mother and infant. Positive oedipal wishes could not be entertained because of the dread of the super-ego again reinforced by death wishes.

She fought against the recognition of transference feelings. Instead she was preoccupied with phantasies of intercourse with various young men. This time she described how the names and the faces were different but the feeling was always the same. One of the names stuck out not because he had meant anything more than the others (in fact she had hardly known him at all) but because of the name itself (there happened to be a male patient in the hospital currently with the same name).

Prior to a holiday break, she reported a dream in which she was going to have intercourse with a Dr Robert Cumming. From her associations it became clear that he had come into her masturbatory phantasies the night before. 'Doctor' referred to the therapist and to this young man's father who was also a doctor. Robert was her father's Christian name and Cumming was the opposite of going (the holiday separation). It became clear that the latent content of the dream consisted of her death wishes against the departing therapist. The dream-work was concerned with the rallying of positive oedipal feelings to combat this. The dream also showed how the sleeping ego employed primary process mechanisms in the service of defence, mechanisms which were to be used freely in the psychotic phase.

Psychotic phase 2

Her anxieties became more pronounced when she learned that her sister had become pregnant. Although insisting that she was delighted she began to make life very difficult at home. She was furious at her mother's knitting for the baby, went into a rage when she put a cake in the oven. She started to knit for the baby but somehow or other the baby wool ended up as a cardigan for herself.

Concern about the therapist's wife became a feature. She reported a cover memory of father in the bathroom wearing only pyjama trousers dabbing her mother's face with shaving cream. Associations to the trousers led to memories from the age of three when she was in bed between them down underneath the blankets playing with the cord. She denied any further memories but became very agitated.

Increasingly over the next few days her sexual feelings bothered her. She thought of intercourse most of the time. Cigarettes and eating helped a bit and there was very frequent masturbation with phantasies of intercourse but nothing could ease her tension sufficiently to stop her agitation. On going home one day she found that she had forgotten her key and her lunch was inside. She panicked because she was sure that if she did not eat immediately, as she put it, she would start having the queer feelings and hearing things. Despite her fear of the consequences, she entered the house by breaking a window.

Within the next few days she was hearing voices and in the following week had to be readmitted with further psychotic symptoms. Following the birth of her niece she rapidly came together and was soon back at home attending as an out-patient. Her mother pronounced her better than she had been for years and she was able to start a course in shorthand, gaining above average marks in her first exam.

Neurotic phase 2

Her sexual phantasies were of intercourse with the young doctor mentioned above.

Interpretation of this in the transference produced further phantasies of the therapist with his wife and his wife's menstruation. Menstruation, for her in this instance, meant that his wife was not pregnant and her associations also included abortion. Her tension increased when the time approached for her brother-in-law's return from the Middle East. She described her fears lest he should harm her sister. Consciously the phantasies were of his hurting her physically. This was associated with preconscious phantasies of their intercourse. The unconscious wish was for intercourse with him herself and this implied the elimination of her oedipal rival, her sister. Shortly after this, however, she learned from the hospital 'grape vine' that the therapist now had in analysis privately, a patient formerly in the same ward. This evoked memories of her resentment of her mother's pregnancy and how she had rejoiced at the infant's death. The following day she also learned that the therapist's wife was having a threatened miscarriage and her psychotic symptoms immediately reappeared.

Her neurotic conflicts were thus understood in relation to the oedipus complex. The partial dissolution of her super-ego in the transference neurosis gave some insight into the ego super-ego relationship. The super-ego is formed with the resolution of the oedipus complex and it consists of the ego ideal aspect which represents the admired and loving parents with the critical agency, representing the dreaded castrating parents. In so far as the individual falls short of the ideal either in thought or in action he is then exposed to the criticism of the other agency and this is felt as guilt. For a sufficiency of self esteem there must be some libidinal gratification for the ego from the super-ego, analogous to the previous relationship with the parents which is now internalized.

In this case the patient conducted a sado-masochistic relationship with her father, provoking him to beat her, and so on. Although punished there was still gratification in the relationship. There was still a fusion of the aggression with libido which enabled her on balance to enjoy it masochistically. There was a similar relationship between her ego and super-ego. It is likely that with the onset of genitality, there was an instinctual defusion. Aggression was no longer bound by libido and thus the previous gratification was no longer possible—hence the narcissistic deprivation.

This patient always displayed a low tolerance for frustration. The recurring theme of loving and then hating illustrated her characteristic reaction—frustration—rage—hate. She usually managed to cope with this by using some of the neurotic mechanisms described above. Whether critical in terms of castration anxiety, or of withdrawal of love, the super-ego was always fobbed off sufficiently for the gratification of her narcissistic needs.

With the forward movement to genitality, however, there was a marked increase in anxiety. It was interesting too that with the appearance of phantasies of intercourse menstruation returned. The upsurge of libido stressed her frustration tolerance even further and this with her usual rage reaction increased her guilt. Thus she was confronted with an increase in both instinctual anxiety and super-ego anxiety. Her aggression was expressed in hatred of the parental intercourse. It appeared that on this account too there was a quantitative increase. The combination of these dynamic and economic factors left her weak ego extremely vulnerable.

PSYCHOTIC PHASE 3

The additional reality factors, so relevant to her conflicts, finally overwhelmed her. The pregnancy of her sister and later of the therapist's wife was the ultimate frustration from reality. There was no longer a sufficiency of love from the super-ego (representing the external world) and expressed in the transference. Her reaction was then to deny reality and withdraw her object cathexes. These were redirected to wish fulfilment phantasies

for purposes of narcissistic gratification. The phantasies were now in the form of delusions and hallucinations.

These mechanisms were seen to operate in the transference setting. An important finding with this patient was how she managed to maintain some object relationship with the therapist however tenuous and, within this relationship, some reality testing and capacity for self-awareness. This was understood as an expression of a conflict-free area derived from primary autonomous development. Only occasionally was it too overwhelmed. Thus, although deluded and hallucinated she mostly knew who her therapist was and usually kept her appointments. Without this splitting of the ego into a psychotic and a non-psychotic part no therapy could have been possible. It was reminiscent of the splitting which occurs in the psychoanalysis of neurotic patients when the self-observing part of the patient identifies with the therapist against the involved part. With the neurotic patient this relationship is implicit. With this patient, in her psychotic phases, this had to be made explicit.

The content of her delusions and auditory hallucinations varied depending on the level of ego regression. The content of these hallucinations and delusions was oedipal and it appeared that the ego regression was not necessarily accompanied by a libidinal one. She described how each night Robert Cumming the young doctor previously mentioned came to her and they had intercourse. She was going to have a baby. After her session she had to hurry away to make his lunch. They were married and lived with his mother. He was in contact with her through mediumship and telepathy. This was a wish fulfilment delusion and the choice of the young doctor represented her infantile oedipal wishes towards her father, as expressed in the transference. The name had been chosen as the result of condensation and displacement (primary process) and had been used previously in a dream. At that time the lessening of repression in sleep necessitated the em-

ployment of these mechanisms by the sleeping ego in an attempt to preserve sleep, that is, in the service of narcissism. The mechanisms used by the 'psychotic ego' were somewhat similar. With the absence of repression, the preservation of the narcissism could only be carried out by denying reality and substituting a psychotic reality. The denied reality in this instance was the pregnancy of the therapist's wife.

During this psychotic phase, the patient would comment on how happy she was but a week or so later there was a change once again before a break in the treatment. She became extremely distressed, complaining that Robert's voice was constantly attacking her through the wireless, television and in the ward at night. He knew all about her and about the dreadful things she had done. He was with her in the lavatory and her gases were getting through to him and his to her. This was announced in an interview when both patient and therapist were smoking. She was terrified lest her gas would poison him.

Her distress increased to panic when the voices told her that Robert was waiting at one end of the hospital and his wife at another. Between them they would punish her for what she had done to their baby. She frequently rang up the therapist at his home and at other places of work imploring him to stay with her to keep the voices at bay.

Interpretation of this material in relation to her death wishes towards the therapist and to his wife and child, and her fears of punishment had no effect. The therapist then stated explicitly that it was true that his wife had been ill, but that she was now greatly improved and that the pregnancy continued. He reminded her that he saw her only four times each week and that this was the realistic limit of what could be offered. He told her that he was fully determined to have his two weeks' break and would come back all the better for it. The need to have him with her all the time was interpreted as her need to reassure herself that he was still alive. He reminded her that

he was merely her doctor and she his patient. She couldn't kill him or his child, nor he her.

There was then immediate understanding from the patient and she was able to admit to the possibility that these ideas had been delusions. By the end of the session she had gained insight although she still felt that the voices would come back when the therapist left. There was no further panic and she survived the break reasonably well. The transition from the period of delusional contentment to the period of persecution resulted from the fact that in this instance her psychotic defence, namely the wish-fulfilling delusion, had broken down. This resulted from the increase in aggression—the reaction to her therapist's departure. She was now ready to exchange her psychotic reality and re-establish the relationship with him because reality itself was now less threatening. His firmness diminished the persecutory element of her projection. It was now advantageous to abandon her omnipotence in order to gain some narcissistic gratification.

The persecution disappeared completely within the next few days but the voice continued, only this time in a friendly way. It would comment on what she was doing—there she was typing, she was a good girl, it was time for her sessions, time for her supper, and so on. This reflected a reconciliation with the super-ego. Once more her behaviour approached the demands of the ego ideal. She was able to see this in relation to the transference and shortly, as she put it, able to turn the voices off. It also meant, however, that by typing, getting up, helping in the wards, and so on, she had repressed her incestuous aims. With the re-establishment of object relationships repression was possible once more and with it the stimulus barrier against external stimuli was again functioning.

SOME COMMENTS UPON THE PSYCHOTIC PHENOMENA

The auditory hallucinations and delusions were complex. Their content consisted of conscious and preconscious phantasies. The perceptual disorders and visual hallucinations which were so common in her first and second psychotic phases were almost entirely absent in the third. Body boundary upsets and feelings of merging were also less manifest. While these are not the subject of this paper it should be noted that they were not necessarily specific transference phenomena. They merely reflected the ego regression and dedifferentiation. For example, there would be merging with anybody she came in contact with, not just her therapist. Unlike her auditory hallucinations and delusions this experience was not related to specific phantasies as reflected in the transference. It may be thought of as similar to the symbiotic phase with the mother, rather than a recapitulation of it.

Utilizing transference reactions as an index, the early relationships with the mother were probably characterized by a very low frustration tolerance. This suggests that this relationship was based upon need satisfaction rather than upon object constancy. How far this low frustration tolerance arises from a constitutional defect, faulty mothering or both, remains to be seen. It is clear, however, that separation and genitality provided stresses which were beyond this patient's limits. The resulting frustration was the trigger for the arousal of intense hate. Her inability to deal with this resulted in a withdrawal of object cathexes and the emergence of the psychosis.

This paper has been concerned with the examination of these pressures as they emerged in the transference. They must not be confused with basic causes. Nevertheless, an exact examination of these internal and external pressures helps to raise further questions many of which may only be answerable by disciplines other than psychoanalysis.

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Treatment dilemmas with psychotic and sociopathic patients*

By HELM STIERLIN†

Morton Sidwick was drunk again.

When he came to his therapeutic hour his eyes were glassy. His hair was unkempt, his hat deeply pulled over his forehead. He uttered half-hearted curses, without the stamina to hurt. Embarrassment, guilt, an appeal to be taken care of—to be cleaned, to be put to bed, to be cuddled—a spoilt child's garrulous reproachfulness toward the whole world— these were the feelings Morton somewhat diffusely and unco-ordinatedly conveyed to his therapist.

In the therapist one feeling overshadowed all others: futility. This scene, in one variation or another, had occurred again and again. Throughout the past fifteen years, which comprised his total adult life, and particularly throughout the two years he had been a patient in psychotherapy, Morton had had such relapses. It was like Nietzsche's 'die ewige Wiederkehr des Gleichen', the eternal recurrence of the same.

Drinking might be seen as Morton's main form of resistance. But here is the rub. The question is, resistance to what? Resistance to change? to insight? to constraint? And in trying to answer this question, it seems to me, the central dilemma of Morton's treatment becomes apparent. This dilemma is the subject of the following considerations.

The term 'resistance', as used to denote a phase or an aspect of psychotherapy, becomes meaningful only when it implies that the patient has an ability and willingness to overcome the resistance; that is, when there is both ability and motivation to change. And it is, in particular, the motivation to change that enables a patient to accept and view himself as a patient instead of as a prisoner. It is certain that even with this motivation the patient will resist change. He will struggle, he will doubt. However—and this is important—even in the very process of struggling he will give the relationship an opportunity to develop into a 'loving struggle', one in which mutual respect and trust can evolve and increase, encompassing ever deeper and more meaningful levels of relatedness.

Willingness to change, or, as it were, motivation for therapy, is found in different degrees in patients seeking therapy. Further, the nature of the change required is often only vaguely in their awareness; many patients, for example, as Allen Wheelis‡ has pointed out, expect relief not from so-called symptoms or clearly definable problems, but from vague feelings of dissatisfaction with their whole life —often finding themselves at great discrepancy with the therapist as to what the problem is and which changes have to take place.

But there are two important groups of patients, where even such diffuse dissatisfaction is either not experienced or not admitted, and where the motivation for therapy appears to be totally absent. They view themselves more as prisoners than as patients. We usually encounter them in a mental hospital. As a rule, they enter the hospital under some outside pressure, be this a more or less subtle

‡ Wheelis, Allen, The Quest for Identity (New York: W. W. Norton), 1958.

manipulation by the family, or a more outright legal committment procedure. These patients are commonly diagnosed as either psychotic—and usually schizophrenic—or as seriously sociopathic persons.

Let me now examine in a little more detail some of the problems resulting from this initial lack of motivation, particularly as it affects the therapy of these patients. With this goal in mind, I return to Morton.

Morton had been labelled a neurotic, an alcoholic, a homosexual, an oral character, a very dependent or passive-aggressive person, a sociopath, and so forth, the label varying with the diagnostic frame of reference, or with the more or less condemnatory attitude of the observer.

Morton had led the life of a playboy. Never having been pressured to earn a living, he spent much money impulsively. He did not seem to care how much he spent. He had many fleeting relationships and many sexual experiences, most of them apparently motivated by a strong need for excitement and thrills. There was much drinking, generally followed by states in which he felt physically weak and nauseated, broodily remorseful, and empty, until, after a while, he felt himself ready for a new drinking episode. He had some interest in sports, literature, and art, but fearing competition, and lacking skills and self-discipline, his endeavours in these fields were aimless and unsustained. However, what appeared most troublesome to others was a kind of drifting, but relentless, self-destructiveness. He contracted venereal diseases; he was involved in car accidents; on several occasions he was beaten and robbed. He seemed to have a tendency to get involved in situations which, if public, would be embarrassing to his socially prominent family. And, as it turned out, it was just such an embarrassing involvement which led his family to exert pressure on him to seek psychiatric treatment in a hospital.

So Morton did not become a patient out of his own initiative, but because this was for him the easiest way out. By becoming a patient he bowed to a stronger power—the pressures and sanctions exerted or threatened by his family.

But just as it was a significant factor in the ensuing treatment that his entering therapy was a means of escape, a begrudged although not inconvenient way out of a difficult trap, it was no less significant that this escapism and the specific power constellation necessitating it were, at the beginning of therapy, clouded in obscurity. In other words, not only did Morton's treatment start out with a lack of motivation, but with a lack of motivation that was camouflaged. The reasons for this are relatively simple:

Both the patient and his family, we find on closer examination, had an interest in keeping the actual power picture blurred, precipitating Morton's admission. And both parties, it turned out, found the most convenient screen for this purpose in Morton's 'medical problem and treatment'.

Thus Morton, although retreating under pressure, by accepting a 'medical treatment' for his difficulties, could hold on to a favourable bargaining position. He could now capitalize on his demonstrated 'co-operativeness'. But, even more important, he could entertain the expectation, so congenial to his basic passivity, that a mere availability was all that was required from him. Like a dental patient, by making himself available to the dentist, he could—in a demanding, welfare-state mentality—expect to be relieved from his troubles. No further efforts of his own were required.

In order to prevent further troublemaking from Morton, the family members were, at least on one motivational level, eager to hospitalize him. But, in enforcing his hospitalization, they also seized the opportunity to emphasize more the 'sick' than the delinquent nature of his difficulties. By viewing his difficulties as medical, just as the patient did, understandably they could more easily keep out of focus their own share in sustaining and possibly contributing to his self-destructive way of life. In this essential respect both

the patient and his family shared a common interest.

Not only the patient and his family, but also the hospital administration, and the patient's therapist, all had an interest in not facing clearly the basic power constellation; that is, they collaborated to keep certain elements in this situation obscure.

The hospital's *raison d'être* is the treatment of sick people. The status and role-definition of its staff members must be confirmed by patients who behave like patients, as persons who are sick and need help.* They are understandably more eager to treat and accept a patient who admits himself voluntarily and who defines his problems as psychiatric, than someone who behaves as if the hospital is a custodial institution, a receptacle for society's troublemakers. This greater willingness to accept a patient who defines himself as a patient can then scotomatize the administration's perceptivity for the more subtle escapist and bargaining manœuvres involved.

The same applies to the individual therapist. In his desire to work with a patient who is seriously motivated to face his problems he may, particularly if he is more eager than experienced, fall prey to similar wishful expectations and distortions of the actual power constellation. At any rate, Morton's therapist did.

Such was the situation at the beginning of treatment. Each of the four parties involved —the patient himself, his family, the hospital administration, and his therapist—had different expectations about the patient's hospitalization and treatment. But each party had some stake in not letting these differences become too overt. And each party, to the degree that his expectations were bound to come to naught, was bound to be disillusioned. The therapist's feeling of futility, mentioned at the outset of this paper, was part of this disillusionment, the seeds of which were laid

* Talcott Parsons has discussed this point more fully in his book, *The Social System* (Glencoe: The Free Press), 1951.

in the very structuring of the therapeutic situation.

Let me now focus on some of the implications for the doctor–patient relationship of an interpersonal situation whose purposes and nature are obscurely defined.

Generally, two main forces can be expected to determine its outcome under such circumstances. First, the needs which each partner wants to fulfil in the relationship; and secondly, the skill and power with which he can elicit from his partner behaviour intended to satisfy his needs.

However, the very obscurity of the actual power constellation opens the field for mutual manipulation and outwitting. This is unavoidable. And this means, among other things, that for a patient operating in this setting, words such as 'therapy', 'analysis', 'rehabilitation', etc., become either useless conventional labels or else weapons of camouflage, covering up—as he sees it—some hidden demand of the therapist, the hospital, the family, or society. What may be intended by the therapist as a therapeutic measure—for example, encouraging the patient to seek a job, offering him an interpretation, etc.—will be reacted to by the patient as a clever move by the doctor to outwit him. Despite the display of amenities, *homo* remains *homini lupus*. If the therapist fails to recognize this state of affairs, it will only strengthen the patient's conviction that the world of human relations is a jungle, while the therapist, deeply discouraged about the outcome of his therapeutic efforts, may part from the patient in an attitude of futility, disillusionment, and punitive resentfulness, possibly reflected in the therapist's eager use of the label 'psychopath'.

In order to elucidate further this characteristic interaction, let me now briefly contrast it with two other somewhat typical therapeutic settings.

The first example is the more classical analytical relationship. This relationship, as is well known, starts out with a rather clearly

spelled out working arrangement, which, as Menninger* has particularly pointed out, has many features of a contract. This contract partly makes explicit the share which each partner is expected to contribute to the working arrangement—e.g. the therapist, his skill and time, the patient, his money—and it partly sets up the framework within which a discrepancy of the needs and goals of patient and therapist, almost inevitably forthcoming in the very process of analysis, can be worked out without a premature break-up of the working arrangement.

From the very beginning, the field for the possible development of mutual manipulation and outwitting is therefore limited. The mutual needs of therapist and patient are channelled into the traditional path of characteristic transactional expression, verbal, gestural, and other, within the analytic hour, which is a contract-bound alliance between doctor and patient.

But, in order for this alliance to be successfully established, certain preconditions must exist. Both doctor and patient must be capable and motivated to hold to the working arrangement. And this requires the patient, when he enters the analytical relationship, to be already equipped with considerable flexibility, stability, and ability for self-observation. In other words, at the onset of analysis, he must already possess a remarkable amount of what is commonly labelled 'ego-strength'.

Yet it is exactly such ego-strength, or at least considerable elements of it, that is usually missing in the second type of specific therapeutic interaction. This second type of therapeutic interaction is the one with the psychotic patient.

The psychotic patient—and I am thinking primarily of the schizophrenic—as a rule is neither able (due to his distortion of reality, and other incapacities) nor willing to enter into a therapeutic alliance as the analytical

patient does. Instead, he enters the mental hospital, which may be regarded as a kind of moratorium.*

That structures a very different situation. Now it becomes the first and most difficult task of the therapist to *build* a relationship out of which the patient can increasingly develop the very capabilities that will enable him to shape his relationship more along the line of a classical analysis, as outlined above. The successful therapy of a psychosis will, as is well known, often tend eventually to merge into a more classical analytical relationship.

In another paper† I have tried to characterize some important aspects and vicissitudes whereby the initial relationship with the psychotic patient differs from the more classical analytical relationship. I mentioned as typical for the relationship with the psychotic patient the inevitably much greater personal involvement of the therapist with his patient, the patient's need to use the hospital as a moratorium which allows greater self-expressiveness, and so forth.

For the purpose of my present study I want to focus only on the aspects of this relationship which might throw light on the treatment situation with the hospitalized sociopathic patient. Specifically, I want to focus on the intermeshing of the needs of therapist and patient, which is bound to evolve, given the patient's illness and the characteristic treatment setting with the psychotic patient. Among other things, it comes about as a result of the unusually long period of treatment required, the patient's frequent lack of inhibition in expressing certain primitive feelings, particularly in the areas of aggression and sex—a patient may, for instance, undress and masturbate in the presence of his therapist—the constant necessity for dealing with

* Erik Erikson has developed in greater detail the concept of the mental hospital as a moratorium. *Identity and the Life Cycle* (New York: International Universities Press), 1959.

† Stierlin, Helm, 'The Adaptation to the "Stronger Person's Reality",' *Psychiatry*, 1959, **22**, 143–52.

* Menninger, Karl, *The Theory of Psychoanalytic Technique* (New York: Basic Books), 1958.

obscure, unconventional ways of communication, assumed to be characteristic of the so called preverbal period of development. All this is bound to bring about a peculiar intermeshing of the needs of therapist and patient. This need-intermeshing frequently is obscure, intense, and anxiety-provoking, but often rewarding and intriguing at the same time.

The need-intermeshing may have the quality of a symbiosis,* presumably containing many elements of the early mother–child relationship, but it might also be appropriate, particularly in the present context, to characterize it as a conspiracy for the mutual satisfaction of fringe needs.† By 'fringe needs' I mean those needs which ordinarily have little opportunity to find expression in conventional life situations, but which constitute nevertheless an often powerful reservoir seeking outlet, for example, in creative expression, but also lending themselves to stimulation by unconventional life situations and by literary works. Leaving out, in this context, the needs of the patient, a few such fringe needs of the therapist, stressed by various authors at one time or another, may be mentioned: The need to live up to the greatest possible challenge; to cure patients who are commonly considered hopeless; the need to feel oneself omnipotent in relation to a human being one may wish to remake in one's own image; the need to defy certain values of conventional society by identifying with the unconventional life orientation of the schizophrenic (which sometimes culminates in such assumptions as 'schizophrenics have a higher integrity than conventionally adjusted human beings'); the

need to establish ties of intense dependency, which can be gratified only through the relationship with a very sick and helpless person; and many other needs, which are more complex, obscure, and less easily identified.

But—and this is centrally important—even though such a conspiracy for the mutual satisfaction of fringe needs tends to become established, there are several mitigating factors operating which make possible a clearer delineation of the roles of patient and doctor. These factors make it possible for an obscure conspiracy, as it is seen from one angle, to become the very basis of a truly therapeutic relationship, which can lead to an increasing reintegration and relative autonomy of the patient.

The main factor in this delineation appears to be the patient's very failure to make an adjustment in the conventional world. Being too torn within himself, too paralysed by conflicting and often dissociated impulses, too obscure in his communications, and too precariously integrated in his environment, he becomes helpless.

This adjustment failure, rooted in his self-incapacitation, makes him actually powerless. And it is this actual lack of power that restricts the scope and possible impact of his manipulative and outwitting manœuvres, which, given his primary lack of motivation, would be certain to evolve.

The hospitalized psychotic patient is very much in the situation of a child whose rebelliousness and manipulations must find their natural limits in the fact that his parents are so much older, stronger, and established in life and society. Only when his parents are as weak and childlike in significant areas can the child's rebelliousness and manipulations succeed. Only then can the child force them to enter with him into a truly harmful conspiracy for the satisfaction of fringe needs, this being the result as well as the expression of a disturbance in the whole family field. Similarly, the psychotic patient finds himself faced with the real strength, integrity, and

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* See footnote, p. 78.

† In another paper, cf. 'Individual therapy of schizophrenic patients and hospital structure'. In *Psychotherapy of the Psychoses* (New York: Basic Books), 1961 (ed. Arthur Burton), I have gone in greater detail into the rather complex balancing process in the therapist, whereby needs in this intense relationship are, in the long run, not gratified in a way which would be damaging to the patient.

dedication of the physician and the hospital community. This is the main guarantee that the conspiracy of fringe needs and the greater self-expressiveness, facilitated by the hospital as a moratorium, will finally help instead of hinder the patient's growth toward greater relative autonomy. Corroborating this line of thought, it seems to me that we frequently find in the long-term intensive therapy of schizophrenic patients a pseudo-psychopathic stage, characterized by much turmoil, 'acting out', desire to leave treatment, agitation among the family, etc. This usually seems to happen when the patient's improvement is reflected in his increasing actual power and corresponding greater ability to manipulate and upset the established family field.

With these brief outlines of two specific treatment situations in mind, let me return to the treatment of the unmotivated sociopathic patient. Unlike the motivated neurotic patient, the sociopathic patient does not voluntarily enter into, and subsequently feel himself bound by, a contract or working arrangement, although he may use words suggesting that he does. In the absence of such self-imposed rules, an intermeshing of needs of therapist and patient is bound to take place, characterized by attempts at influencing each other and at making the best of a given situation. Such an intermeshing of needs, described above as a symbiotic involvement of patient and therapist, as a conspiracy for the gratification of fringe needs and so forth, is, as we saw, typical also of the second, above-described treatment situation; namely, that of the equally unmotivated psychotic patient.

But—and this is essential—the adjustment failure of the sociopath is of quite a different nature from the failure of the schizophrenic. Although he recedes in the face of a stronger power—temporarily, as he may believe— embodied in family pressures, court orders, etc., he has not become actually powerless in the same sense the hospitalized schizophrenic patient is helpless. The sociopath fails to adjust less by an inefficient ego, incapacitated

by terror, withdrawal, and the threat of disintegration, than he does by the miscalculations of an ego still capable of goal-directed action. It is, therefore, not so much what might be called an ego-defect that brings the sociopath into treatment with the psychiatrist, but rather a kind of stilted normalcy, a deviance from others less in terms of intelligent adjustment ability, than in terms of deviant values, of a pleasure principle that is hypertrophied and egotistically narrowed at the same time.

Yet, by the very fact that the sociopath is less obviously sick or crazy than the psychotic patient—at least when viewed in the light of conventional behaviour—he is bound to bring into his relationship with the therapist a dimension of potentially dangerous realness and self-questioning by the therapist.

In the psychotic patient it is the very fact of the patient's obvious craziness which precludes the therapist's feelings ever becoming more than feelings. For example, feelings of wanting to marry a patient, to cuddle him, etc., are safely buffered from actualization by the therapist's awareness of the exceptionality of this characteristic treatment situation with the psychotic patient. In fact, it is this safeguard—the knowledge that all these feelings, as real as they appear at the moment, are merely phantasies that have no real chance to be crystallized into consequence-bearing action, combined with a considerable ability of the therapist to feel but not to act upon his feelings—which opens up a new dimension of self-experience in the therapist who treats the schizophrenic, as is discussed in the writings of Harold Searles.*

Not so with the sociopath. His greater closeness to reality, combined with a deviance of values, is bound to give his relationship with his therapist a different, but characteristic, threat and flair. Just as there is

* Searles, Harold, 'Oedipal love in the counter-transference, *Int. J. Psycho-Anal.* 1959, **40**, 1–11. 'Positive feelings in the relationship between the schizophrenic and his mother', *Int. J. Psycho-Anal.* 1958, **39**, 1–18.

frequently bound to occur in the intensive therapeutic involvement with the schizophrenic, a *blurring of feeling boundaries* between the therapist and his patient, there will occur, in the treatment of the sociopath, a *blurring of value boundaries*, which can hardly be less stressful. With this blurring of value boundaries I want to deal in the following.

This blurring of value boundaries, it appears to me, is the result of a moral conflict, which the treatment situation forces the therapist to face. But this moral conflict seems to be so deeply rooted in the culture in which we live as to appear to be almost insolvable. Why?

In present times the progressing liberation of modern man from the daily chore of labour has made available to him an unequalled amount of surplus energy. Various aspects of this development have been dealt with by Riesmann,* H. Arendt,† Galbraith,‡ and many others. In the context of this study, at great danger of oversimplification, it must suffice to point out that this development resulted for many people in an unparalleled availability of careers, hobbies, and creative occupations, but also—this being the other side of the coin—in a revolution of desires, a hunger for constantly stimulated consumption; in brief, a search for pleasure or happiness which is bound to become only more intense and restless as the means to achieve it seem to become legion.

This search for happiness and stimulation, it appears, frequently takes on the form of a search for a Disneyland that promises us the wonders and pleasures we once expected—and seemed to find—in childhood. The childhood pleasures have gone, but pleasures and experiences of a similar intensity, irresponsibly enjoyed, appear to be available to certain

* Riesmann, D. *et al.*, *The Lonely Crowd* (New Haven: Yale University Press), 1950.
† Arendt, H. *The Human Condition* (New York: Doubleday and Co.), 1959.
‡ Galbraith, J. *The Affluent Society* (Boston: Houghton Mifflin), 1958.

groups of people, for instance, prostitutes, playboys, drug addicts. They impress us often as the inhabitants of a Disneyland for adults. By this I mean a realm wherein the intricacies and complexities of normal human relatedness, resulting from established customs and an awareness of the consequences of our actions, seem to be suspended. This is really not the case, as is well known. The residents of this Disneyland are not exempt from the laws of everyday life. It means, among other things, that they often have to pay a formidable price for their seeming shortcuts to pleasure and thrills in terms of loneliness, lack of a future, of proneness to deep depressions, to boredom when the sparkle of excitement, artificially ignited, fades. But it is an essential feature of this Disneyland to be like the laughter of a clown who off-stage is deeply sad. The public only sees the laughter, and the price-tag attached to this Disneyland is seldom clearly visible to most people. It becomes submerged in a maze of seeming fun and intensity of experience. And consequently it lends itself to becoming the peg for much craving for happiness and pleasure. Many vicarious experiences like movies, television plays, etc., are offered and sought to make this realm accessible.

This, however, means, when seen from a somewhat different angle, that these vicarious experiences constantly tap the reservoir of fringe needs that exists in all persons.

The media providing vicarious experiences in our society exist in tremendous variety and they are geared to different degrees of taste and sophistication in the recipients. There is an imperceptible transition from the more simple products of the modern dream mills to works of literature such as Nabokov's *Lolita*, the plays of Tennessee Williams and many other creations. Despite great differences in the degree of sophistication, scope of meaningfulness and artistic presentation, they can serve as an indicator from which we can infer the nature and quality of human fringe needs which, in one form or another, strive to find a mode of experience or expression.

However, in using the products of the dream mills as well as the popular works of literature as an inference basis for existing fringe needs it becomes apparent that these needs are not altogether harmless and peripheral. These needs, it becomes evident, are closely tied up with and merge into stronger passions and proclivities which, once aroused, may pressure us into action. They merge into what, from a conventional viewpoint, sometimes can only be labelled as either crazy, perverse, or criminal attitudes and strivings. It is this fact—the inherent threat to established customs and standards of decency—that makes them so important to us.

This inherent threat is often bound to pose, on many different levels of experience, a conflict which has vexed moralists and thinking persons of all times. It seems to be accentuated in our age and society as a result of the above-mentioned developments. In very general terms, the conflict arises from the fact that the stimulation of our fringe needs possibly promises to enrich our scope of inner experience while threatening at the same time our moral integrity.

The positive quality in experiencing something which conventional reality would ordinarily bar from us, is perhaps best reflected in the life of Goethe. He, like few other human beings, looked upon life as a process of increasingly complex self-expression and self-unfolding to be achieved by a constant assimilation into one's personality of many complex and varied experiences. It was natural for him to say, as he did, that he could conceive of no crime which he himself might not have committed.

But this very statement reflects also the threat inherent in this position. For when we relate to people and act in a world where decisions have to be made and the consequences of these decisions to be faced, the destructive potential of fringe needs and hidden passions appears in a different light. Then a disposition to murder *is* a disposition to murder.

It can be argued that artistic expression,

vicarious experience, or the acting out in phantasy of fringe needs and hidden passions may be the surest—and perhaps the only—way of preventing them from being acted upon just as the driver who consciously experiences his rage is less prone to cause an accident than one whose rage, unbuffered by the awareness of it, finds more easily an impulsive short-circuit to the accelerator. But in order that this neutralization—in a way an essential process of all therapy—may take place, some basic values of the individual have to be already clearly established. And this is central. The driver must already know, for example, that an accident can be a terrible thing. He must be sensitive to the misery it could entail.

It is, instead, characteristic of the above-described conflict that, because of the very way we are stimulated to fringe experiences or passions, the legitimacy of these passions as motivating forces becomes the issue. In other words, this conflict poses itself then, when we feel the very process of value formation and value confirmation itself to be at stake, when the appeal of fringe experiences contains the appeal to re-orient our values. It was this value conflict that made, for example, Plato* want to ban bad poets from his republic—those poets extolling bad models and thereby setting up bad values for the youth, which proposition brought him dangerously close to the policies of modern totalitarian dictators.

A modern case in point, highlighting the same conflict, is Bert Brecht's *Three Penny Opera*, whose hero is totally irresponsible, a murderer and a rapist. Analysed soberly, the

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* 'Then the first thing will be to establish a censorship of the writers of fiction, and let the censors receive any tale of fiction which is good and reject the bad; and we will desire mothers and nurses to tell their children the authorized ones only. Let them fashion the mind with such tales, even more fondly than they mould the body with their hands; but most of those which are now in use must be discarded.' *The Republic*, p. 45, *Collected Works of Plato* (New York: Greystone Press).

play, by glorifying this odious hero, displays an utter cynicism, debunks and ridicules the values of friendliness, helpfulness, and human compassion. But this play, because of its fringe-appeal and skilful presentation, became one of the greatest theatre hits of all time; first in its original German performance in the early twenties, and again in its American off-Broadway revival, which has run for many years and is still running.

The value issue, implicit in the presentation and acceptance of the play, has been clearly demonstrated by Hanna Arendt's analysis of the German public's reaction to the *Three Penny Opera* during its original performance in the early twenties.* The play's depiction of modern man as basically amoral, sadistic, and cynical was, as Hanna Arendt stated, not experienced by the audience of the play any longer as a social protest nor as an indictment of present society or of certain groups within this society; instead it was experienced by nearly everybody as the long overdue confirmation of man as he really is. In other words, the ones accused of base motives, that is, the members of bourgeois society, enjoyed being 'found guilty' of having them, deriving from this a self-enhancing pleasure, just as a movie queen may enjoy a scandal in the sure knowledge that it will increase her appeal and box office value. As was proven by the subsequent political events in Germany, the lines between aesthetic confirmation and official sanctioning of sadistic and amoral behaviour became increasingly blurred. Many Nazis prided themselves for being 'political realists', that is, for being unhypocritically cruel and power-oriented, out-Machiavelling even Machiavelli.

With this in mind, let me return to the treatment of the sociopath. It may become clearer now why the blurring of value boundaries, occurring in this situation, frequently is so difficult to resolve. For, inevitably, this situation, at one point or another, must stir

* Arendt, H., *The Origins of Totalitarianism* (New York: Harcourt, Brace and Co.), 1951.

up the above-described moral conflict that is built into our present cultural situation and maybe even into our basic human existence. When we are sensitive and prone to empathize with a patient, the sociopath, by his very presence, cannot help but make us see the destructive consequences of the values embodied in his needs and actions, just as this would be the case for a politically sensitive observer of the *Three Penny Opera* in pre-Hitler Germany. In other words, by entering a more intense relationship with him, the sociopath often forces us into the dilemma of either becoming, though possibly unwittingly, his co-sociopathic accomplice or of becoming shakily and legalistically self-righteous, this self-righteousness easily turning into a more or less disguised punitiveness.

In the course of Morton's treatment this characteristic conflict was activated again and again, being the basis, I believe, for much manifested indecisiveness and contradiction of policy, not only displayed by his therapist, but by the administration as well. His above-mentioned relapses into drunkenness may, in the light of the foregoing, be viewed as one focus for the crystallization of this conflict. (This drunkenness, of course, as all symptoms, has many complex angles and determinants which are not considered in the present context.) Evidently drunkenness was for Morton an escape from unbearable pressures, an impulsive and perhaps magical way of avoiding anxiety, internal conflict, and the facing of realistic problems; but it was *also* a short-cut to pleasure and kicks, against which in many complex ways our society has erected many repressive barriers (reflected, for example, in the 'Blue Laws').

These barriers have been internalized by the members of society; they have become part of their value make up; but this leaves open in many people a constant leverage for temptation which has to be counterbalanced by newly repressive measures, e.g. exhortation, threats, emphasizing the values of decent and sober behaviour, and so forth. Yet Morton, by his very presence, embodied a

threat to this balance which each individual with more or less inner freedom has established for himself. He flauntingly demonstrated not only that one can use this pleasure short-cut and, for many years, get away with it, but also that society tolerated and facilitated this. For Morton was not a literary figure nor phantasy object, he was a live messenger from one of Society's established Disneylands where drunkenness, playboydom and perverse kicks are seemingly allowed to flourish. Therefore, whether his therapist tried to understand Morton's drunkenness as a perhaps inevitable form of acting out or whether he tried to counter it with a reformer's zeal, frequently he could not avoid the above-described characteristic conflict, which to some degree, I believe, had its roots in the culture itself.

CONCLUSION

At the beginning of this study a question was posed: What must take place in order that a human being turned into a patient by an act not of his choice, but, as he sees it, by an unlucky stroke of fate, to *accept* himself as a patient? In other words, what, in the relationship between him and his doctor, must occur to bring about the change from unmotivatedness to increasing co-operation? In order that this change may take place, I believe the therapist has to understand the intricacies of the setting within which he has to operate. In the absence of rules, mutually spelled out and agreed upon by therapist and patient, the relationship both with the psychotic and with the sociopathic patient is fraught with characteristic vicissitudes and problems. I have tried to throw some light on a few of these problems and to point out some similarities and differences found in these two groups of patients. These problems, I believe, in order to be worked through successfully, not only require an assessment of the needs of the therapist, but also of his values as they arise out of his interaction with and understanding of the culture in which he is living and as they come to form the very core of his personality.

Community methods of treatment

By M. C. MOSS* and P. HUNTER†

This paper sets out to describe an experiment in Community methods of treatment which was started in June 1961 in a ward consisting mainly of chronic psychotic patients many of whom were disturbed with consequent behaviour problems. It was felt that the use of group pressures on a disturbed individual would be a valuable adjunct to drug therapy in assisting that individual to control her behaviour. It was hoped to promote self reliance, self respect, initiative and a feeling of being accepted which, as is all too well known, are qualities sadly lacking in the chronic patient of a psychiatric hospital, especially if the patient has been admitted to a psychiatric hospital on several occasions. We felt that such a procedure would free communication between patients and members of the staff, and, more importantly, between various members of the staff themselves by use of staff meetings. It was also envisaged that the role of the mental nurse would become clearly defined and an emphasis laid on working as members of a therapeutic team. One further hypothesis we wished to test was whether this experiment could succeed without a specially selected staff or whether the Henderson Hospital, for example, were right in feeling one must start with certain 'core' personnel, who are imbued with the unit ideology, and that other staff should preferably come with no previous experiences and with attitudes unformed.

Community methods of treatment were used by Bierer among chronic patients and

reported by him in 1948. He conducted the meetings on a superficial level with an elected chairman from the group, and the psychiatrist was in the background. The advantages claimed are set out in his brief report. Other experimental therapeutic communities have been established and the subject is well reviewed by Kraupl Taylor (1958). Rapoport (1960) in his detailed study of the Henderson Hospital—*Community as Doctor*—described their experience with groups.

The ward chosen for the experiment was Nelson ward, the most disturbed in the hospital, consisting of forty-five female patients whose ages range from 15 to 75 years. The commonest psychiatric diagnosis was chronic schizophrenia (all types) with varying degrees of deterioration. Other diagnoses were psychopathy with subnormality, post-encephalitic Parkinsonism, epilepsy and the affective disorders. The group could be considered an open one, as admissions and discharges were made directly to and from the ward, and there were also inter-ward transfers. The usual reason for transfer into the ward in question was disturbed behaviour. Disturbance, both individual and collective, was a common occurrence in this ward though not in the sense that there was any 'group feeling' present. Like most wards of disturbed patients there was very little evidence of this being anything but a ward of individuals, although some patients were indeed capable of forming one to one relationships, and others of forming relationships within small groups. The total number of patients who were admitted directly and by transfer was thirty-six for the year 1 January 1961 to 31 December 1961, and the number who were either discharged or transferred to another ward was thirty-eight. Every ward in the

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hospital has been open for over 5 years, the process being carried out gradually, two or three wards being opened every year, starting 10 years ago. The hospital provides ample facilities for occupational therapy, recreational activities and social intercourse.

Meetings took place twice a week consisting of as many patients as were physically able to attend and all available nursing staff, usually between five or six, which included the sister of the ward, her deputy, staff nurses, nursing assistants and student nurses. Apart from the student nurses, who change wards every three months, the nursing staff had all had long experience on this particular ward, and were regularly employed there. In addition the psychiatric social worker (P.H.) and the psychiatrist (M.M.) were present. The meetings usually lasted for 45 minutes and any topic could be brought up by any person at the meeting. The doctor usually opened and closed the proceedings, and took part in the meetings on a permissive, non-directive basis. Free-floating discussion was the pattern of the meeting and as far as possible patients were encouraged to find the answers to their questions themselves. Immediately following the main group meeting was a staff meeting also of approximately 45 minutes, which was attended by the psychiatrist, P.S.W. and all available members of the nursing staff who had attended the previous meeting. At both meetings there was tacit recognition of the psychiatrist as leader of the therapeutic team, but nevertheless each staff member was made to feel that he or she had a definite role to play in the team. Before the meetings began we had one staff meeting to discuss the proposition and invite support. In retrospect we would agree that more preliminary staff meetings should have been held, but then we wonder, would we have started at all?

At the very first meeting the psychiatrist firmly stated that all ward chores should be done by the patients themselves, as there were a sufficient number capable of doing them. This included the making of beds, cleaning of the ward, distribution of food and the washing-up. This was in fact the only direction firmly given and it was stated that if the ward were neglected the patients had themselves to blame. The nurses were asked to adopt a permissive role, encouraging the patients to work, but not doing the domestic work themselves. Instead they were to initiate interest groups, give out drugs, nurse the physically sick, encourage initiative among the patients and so on. This role of the mental nurse is more fully discussed by one of us (P.H.) (1962) and reported elsewhere. The first reaction of the majority of the patients was to reject their new duties out of hand on the grounds that the nurses were paid to do these jobs, and that they were in hospital for a rest because of their 'nerves'. This was firmly refused on the grounds, stated at the meeting by the psychiatrist, that nearly all patients were physically capable of looking after their ward, and also that if they could not do simple ward chores they would be hardly capable of running a house or living independently. After a period of approximately 5 to 6 weeks no further refusal was openly heard at the meetings, and in fact the patients settled down to looking after their ward. At a further meeting the patients decided that those who worked in the ward were to be remunerated at a level commensurate with the amount done, to be decided by the ward sister. In fact the principle of 'no work—no pay' was set out by the patients and adhered to by them.

This change of role for the nurses and loss of function as a near-domestic was a very hard one to accept, symbolizing as it did the laying aside of a collective defence acquired over years, against the stress of working with disturbed patients in an environment where they had no support except from each other, and where no attempt was made to achieve an understanding through discussion. In the first few weeks the situation was met with a collective denial on the part of the nursing staff, as they saw themselves without a role and were frustrated and angry. They complained bitterly at the 'fall in the standard of

hygiene' and at the number of patients who were not doing anything. This problem, of staff feelings and attitudes, has been, without doubt, the most difficult to work with, particularly as we felt that discussion in the staff group should be patient orientated, and that this meeting should not be allowed to become a treatment group for staff. Asking the nurses to change, and to think about the reasons for individual and group behaviour placed a considerable strain on them. This resulted, amongst other things, in active denial; for example, the denial that discussion had taken place about their change of role, and denial that participation and encouragement were preferable to ordering. It also resulted in projection—for example the doctor and P.S.W. were accused of continuing to discuss a particular patient week after week when the staff were in fact continually raising the subject themselves—and in displacement—in particular anger was expressed at the P.S.W. which was really appropriate to the psychiatrist concerned. This last changed when it was felt safe to express anger against the psychiatrist personally. Throughout this process of nurse adjustment, a lot of support and acceptance of feelings has been needed.

After the first few meetings an element of hopefulness arose mixed with surprise at the response of the patients to the situation, particularly at the way they contributed to the discussion in the ward meeting, and at the changed behaviour of some patients following criticism from their peers in the meeting. For example, one patient who had recently been readmitted, was tense, angry and very critical in the meeting at numerous ward arrangements, particularly at the idea of patients contributing to the community by working. The question of her anger was taken up in the meeting, the patient telling that she was angry because she felt that she was let down when she was admitted. She said that she was told her stay would be of only three weeks duration; she was however detained under a treatment order when she wished to leave against advice. Following this discussion,

which was later continued in the staff group, the patient modified her attitude and was able to start co-operating in ward activities. Another example was that of a very difficult young patient who frequently broke windows, and when criticized by fellow patients she cried, apologized and did not break any more for several weeks. These initial successes eased the situation internally, but meanwhile pressure began to be exerted from outside the ward by other nursing staff and considerable phantasy was generated about what was happening. To some extent this was overcome by having visitors to the ward meetings, particularly student nurses, and also by discussion with the various staff concerned.

Rapoport (1960) had described the oscillatory process of the meetings at the Henderson Hospital, the fluctuations between social equilibrium and disintegration. This pattern was followed with the Nelson ward meetings, in the reactions and behaviour of staff and patients. A few weeks of hope and achievement would be followed by rising tension, disturbance, criticism, and demands from the nurses for more sedation, electroplexy, or transfer of a patient. This gradually rose to a crescendo, there was an explosion, relief, followed by comparative stability with feelings of progress being made. One such crisis, 5 months after the meetings began, developed over a period of 3 weeks. It was noticeable in the way that nurses were absenting themselves from the meetings stating that they were too busy with other duties. Of the events contributing to the nurses' behaviour the following was seen as significant. A patient in an adjoining ward had committed suicide and there was anxiety that a certain patient of Nelson ward might do the same, while another patient had relapsed after a series of rejections. The main meeting had decided that the latter should have another chance and be allowed to return to her work in a hospital department, but this was opposed by some of the staff. The result was that this patient became disturbed again a day later. Another event was a hypomanic patient who was re-

admitted. On the day that the crisis was reached the psychiatrist was unable to attend the ward meeting which was disturbed by a hypomanic patient who made frank and penetrating comments. Another new patient said the situation was unbearable on that day, which was true. Eventually the meeting settled a little, restoring a semblance of order. This situation was reflected in the attitude of the staff, who expressed anger at the absence of the psychiatrist. With the nurses feeling that they had been let down by the psychiatrist, the staff meeting instead of following the staff-patient meeting as usual, was not held in his absence (as it would normally be) but was arranged for the same evening. The evening meeting which was attended by the psychiatrist was peaceful, constructive, and ended with good feeling all round. Within the next few days the ward became settled again.

During periods of comparative stability, intensive efforts were made by nursing staff in various directions, organizing groups for work, and for social activities with the patients. Play-reading groups, swimming parties, and wild-flower competitions were started and patients were encouraged to go shopping, take part in various games and, of course, join in the usual range of hospital activities.

So far each crisis had led to a step forward in the understanding of the staff group. A turning-point was reached when the problem was posed by a nurse, as to how to control a disturbed patient, without at the same time impeding any chance of change for the better. Consistency was seen as a first requirement, and it was admitted that this was the main thing lacking. It was felt that one way of dealing with this situation would be to institute a system of rewards and punishment to fit disturbed behaviour. This theme had already been discussed on many occasions, both in the staff and staff–patient group. The first resistance to this was expressed as an inability to do this without the special training of a nurse who works with subnormal patients. After this had been interpreted as evidence of

the mixed feelings of the staff towards the patients, and after it had been accepted that patient disturbances disturbed the staff, it was recognized that the basic principles are the same with any group of patients and could be applied by the ward staff. This meeting ended, after a lot of frank discussion, with the staff feeling relieved and generally more settled. The sister then arranged a meeting of day and night staff on taking over in the morning, so that communication was enhanced and staff could be aware of the behaviour of individual patients during their off duty period and so adjust their approach.

Some of the most important results achieved by the experiment are set out below. A forum to release pent-up aggression against the staff, the hospital, other patients in the ward, relatives, etc., was provided. The reason for the aggression was discussed by the group and remedial measures if indicated were suggested and acted upon whenever feasible. Because of this discussion of the behaviour by the group, a better tolerance emerged. Also, it did correct disturbed behaviour by criticism from the group. Interestingly, the patients recommended punishment by being put to bed for 3 days, and rewards by restoration of privileges, as a method of choice for dealing with psychopathic aggressive behaviour. Where verbal aggression and paranoid outbursts of a frankly delusional nature was voiced, the delusions were in several instances correctly interpreted as false beliefs by the group, and attributed to illness. Seclusion was firmly rejected as a method of handling disturbed behaviour by the patients, and many spoke of experiences of many years ago, stating that the procedure only increased fear and worsened aggression.

As the experiment progressed the topics discussed changed from criticism of the hospital and its deficiencies, to the nature signs and symptoms of mental illness as observed in the ward, the reasons for their admission and continued presence in the hospital, and what should be done by patients and staff to assist in discharge. On many occasions the

need to remain in hospital was apparent to the patient members of the group. It was observed that initially only a few patients took a verbal part, and a few more were aware of the material discussed. As group cohesion developed more and more patients took part till after 4 months approximately one half were contributing verbally and the majority were aware of the material discussed, while some reacted with non-verbal responses (expressions of anger, approval, smiling, nodding of the head, etc.). At this stage it was fairly obvious to the authors that more and more patients were shedding their apathy, and becoming interested in what was said at the meetings. An interesting observation was immediate and whole-hearted sympathy for the physically ill by both the patients and nursing staff. There was less sympathy for the mentally ill unless the manifestations were particularly obvious and none for psychopathic behaviour. The last-named was patently evident, and was rejected out of hand by most nursing staff and patients as a condition warranting treatment.

We feel that the patients have developed a better knowledge of some of the more bizarre features of mental illness, because of frequently witnessing at the meetings impulsive behaviour, inappropriate affect, verbal responses unrelated to the topic under discussion, frank delusions of grandeur or persecution, mannerism, etc. In this way, it is felt that because there is some awareness of other patients' symptoms, the patient herself may be getting some insight into her own signs and symptoms, and this is particularly true when the patient's illness has temporarily remitted.

An increase in the patients' self-confidence and ability to make decisions for themselves has been seen. There is also an increase in their initiative, spontaneity, and interest in their surroundings. Particularly noticed was the absence of their previous subdued manner and we believe that the meetings have promoted the development of self dignity. The patients feel less dependent on the staff and

have been made to feel like human beings with a life of their own, for which they are themselves in no small measure responsible. They make decisions relevant to the running of the ward as far as possible, and consistent with the hospital rules. Above all we believe that patients feel they are accepted within their own group and have a sense of belonging. This is particularly useful for those patients who for various reasons expect to remain in hospital for an indefinite period and know they have little prospect of being returned to the community outside. One of the noticeable features during the experiment, which is still proceeding, is the spontaneous help meted out by one patient to another. This may consist of simple procedures like making cups of tea, to more demanding ones like looking after a runaway patient for short periods. However, little change has been seen so far in the behaviour of the most disturbed patients. In the case of two young girls, what was once continuing disturbance is now a fluctuating situation, with periods of comparative stability, being followed by periods of disturbance.

The impact made on the nursing staff has been equally revealing. Through the medium of staff meetings, patients' illnesses were discussed, comments invited as to current management and suggestions welcomed. Criticism was freely offered and the pros and cons for any particular line of action fully discussed. Difficulties encountered by the nursing staff in the management of any particular patient were discussed, and quite often seen to be related to their own personal difficulties and attitudes. This is particularly noticeable when the reasons for favouring some patients, and relatively disliking others, were under discussion. From the proceedings of the staff meetings it turned out that inconsistent nursing attitudes towards patients were often prevalent, and after discussion this was corrected. All staff meetings were held in an informal atmosphere and members were encouraged to say what they thought should or should not be done. This provided an excellent opportunity for the psychiatrist to be

aware of his team members' attitudes, and quite often it was unexpected and revealing. For example, several members rejected psychopathy as an illness and thought the patient was being bad. This directly led to less sympathy for the patient and consequently a vacillating nursing attitude, with resultant ill-behaviour persistent in the patient. Staff members discussed their own attitudes, saw the need for their defences, and eventually provided for a *consistent* attitude, even if it were not wholeheartedly sympathetic.

From our experiment we believe that the psychiatrist should be prepared openly to accept criticism from both patients and staff regarding the management of patients. We believe that this can be done without any undermining of the position of the psychiatrist as leader of the team. Often the criticism particularly from patients is invalid and it is then thrown back to the group for their consideration. Valid criticisms are accepted and it is surprising that both patients and staff appreciate the difficult role of the omnipotent psychiatrist which many patients believe him to be. An increasing awareness of the part that nurses have to play in the patients' therapy, and the patients themselves have to play in their own recovery, were fully brought out.

Some further comments appear to be fundamental to the problem of ward management and human relationships. John (1961), in her recent publication *A Study of the Psychiatric Nurse*, drew a doleful but realistic picture of the mental nurse in action. The reasons for this are many, being well known, whilst the solution is variously seen in better training, enhancement of status and increased discussion between staff members. To us, this last appears the most important. In a good many cases, the individual forms his attitude on the basis of the values and norms of the group he joins. He becomes a good member to the extent to which he assimilates the norms, conforms to them and serves the aims demanded by them. For the young student nurse recently entered into psychiatric hospital work this has tremendous im-

plications. In the nurse training unit the ideology of the 'therapeutic community' underlies teaching of psychology, psychiatry, ethics and nursing techniques, but, on the ward the nurse belongs to a staff group and is subjected to the prevailing attitudes. Entry to the ward is a traumatic experience, the student needing to make a rapid personal adjustment to combat the anxiety caused by the impact of mental illness. Anyone familiar with mental hospitals will know how disturbing this can be. The traditional defences in institutions is the growth of 'we' (staff) and 'they' (patients) attitudes and, in mental hospital, a preoccupation with domestic duties and routine, aimed at reducing personal involvement with patients to a minimum. Unless the student nurse is mature, once she has left the training unit, she will rapidly lose the attitudes current there, and begin to acquire the prevailing attitudes of the staff group with whom she works. This can lead to conflict and the adoption of double standards; one to the outsider according to the expectations of the outsider concerned, and one to the reality situation of attitudes held by nursing staff amongst themselves. In these circumstances, little or nothing is contributed to the desired gradual dissemination of progressive ideas, which form the basis of training, throughout any hospital. In this situation we feel that if change is to take place within the psychiatric hospital, then staff, and new staff in particular, must be given adequate support. The idea of the team approach should be expanded so that closer contact is maintained between psychiatrist, P.S.W., occupational therapists, and nurses, with ward groups holding frequent discussions about the problems presented by patients' illnesses and behaviour.

Summary

An experiment using community methods of treatment with chronic psychotic patients is described. We feel it is a useful adjunct to other methods of treatment.

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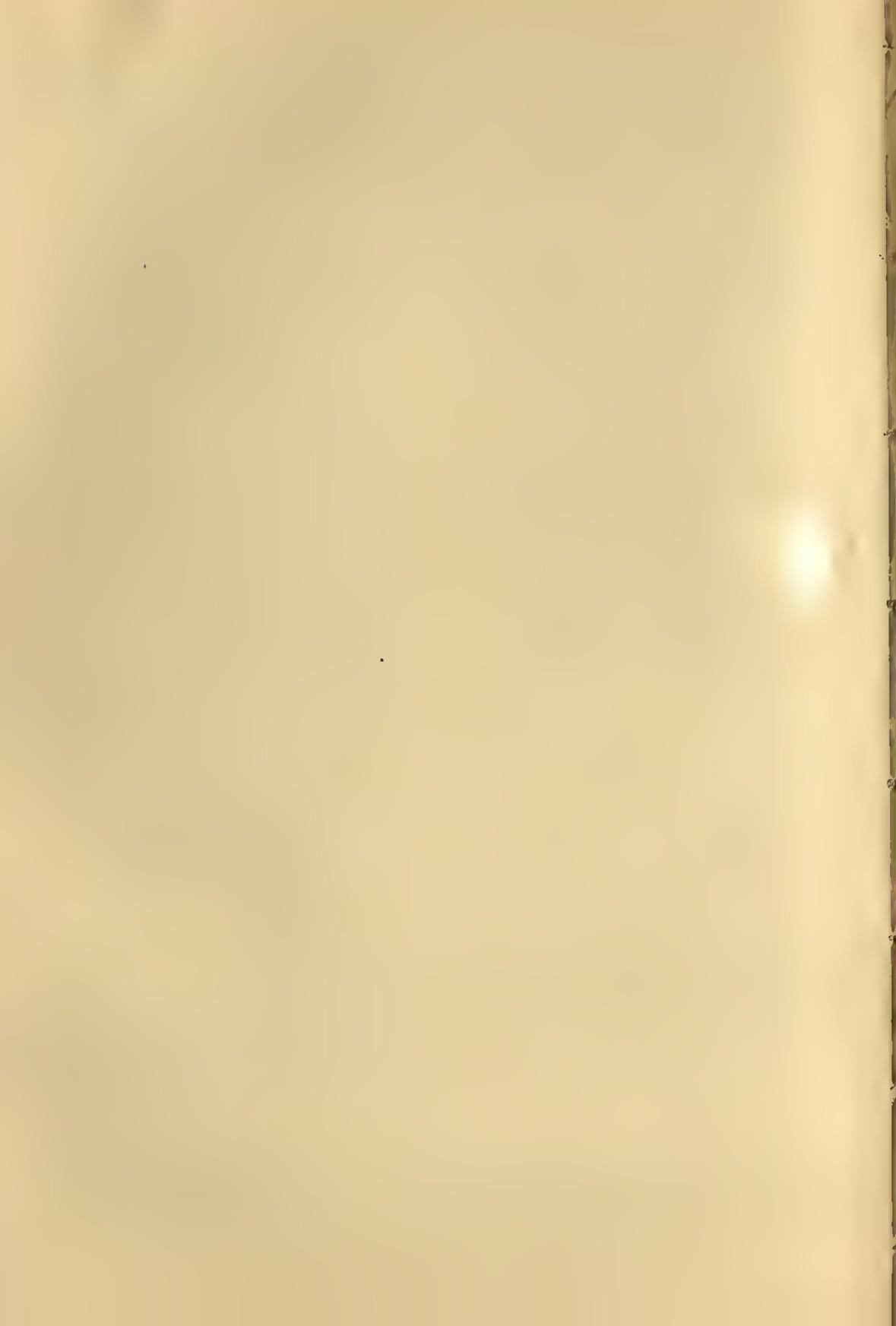
Editorial

The British Journal of Medical Psychology was created to meet the needs of medical men who were interested and preoccupied with the psychological causes and treatment of mental disorders. The *Journal* also provided a platform for non-medical psychotherapists whose interests were in fact identical with those of their medical colleagues.

Since the 1939–1945 War a new type of clinical worker has entered the mental health field—the non-medical clinical psychologist. Under the editorship of Dr J. D. Sutherland the pages of the *Journal* were opened to articles written by clinical psychologists. Some of these publications were of a descriptive nature, others made free use of testing and statistical techniques. This development was made possible by the fact that Dr Sutherland had a wide training and experience in psychology prior to his undertaking his psychiatric and psychoanalytic studies. This made it possible for him to estimate the value of all types of article which were submitted to the *Journal*.

When the time came for Dr Sutherland to retire from the editorship the *Journal* was in the position of having to cater for at least two separate types of article—on the one hand those which belonged to medical psychology and on the other hand those which were clinical psychological with their greater emphasis on testing situations and statistical method. The situation was a difficult one because apart from the *Journal of Mental Science* there was no other British Journal apart from our own which could provide a platform for those clinical psychological articles which were now appearing in considerable profusion. It required an expert knowledge of the subject to decide which of these papers should appear in view of the limited available space.

On the recommendation of the Medical Section Committee the Council of the British Psychological Society decided to institute a joint editorship comprising a medical psychologist, Dr Main, and a clinical psychologist, Dr Sandler. In this way the problem which faced the *Journal* was simply solved. Judgement upon the value of a clinical psychological article could now be quickly made by an editor who had an extensive knowledge of all aspects of the subject. Dr Sandler was a particularly good choice in this respect because of his training in general psychology, in statistical method and in psychoanalysis. Of equal importance was the fact that Dr Main's extensive psychiatric experience as well as his training in psychoanalysis ensured that the *Journal* maintained its medical character.

The *Journal* has flourished under their joint editorship. Circulation has greatly increased and the prestige of the *Journal* stands high in all parts of the world. The position has changed considerably since 1955. The advent of the *Journal of Social and Clinical Psychology* has eased the pressure considerably. The new editor is thus freed of a difficult task which constantly confronted his predecessors. It is now his pleasant task to pay tribute to their conscientious, constructive and arduous labours of the past five years.   T. F.
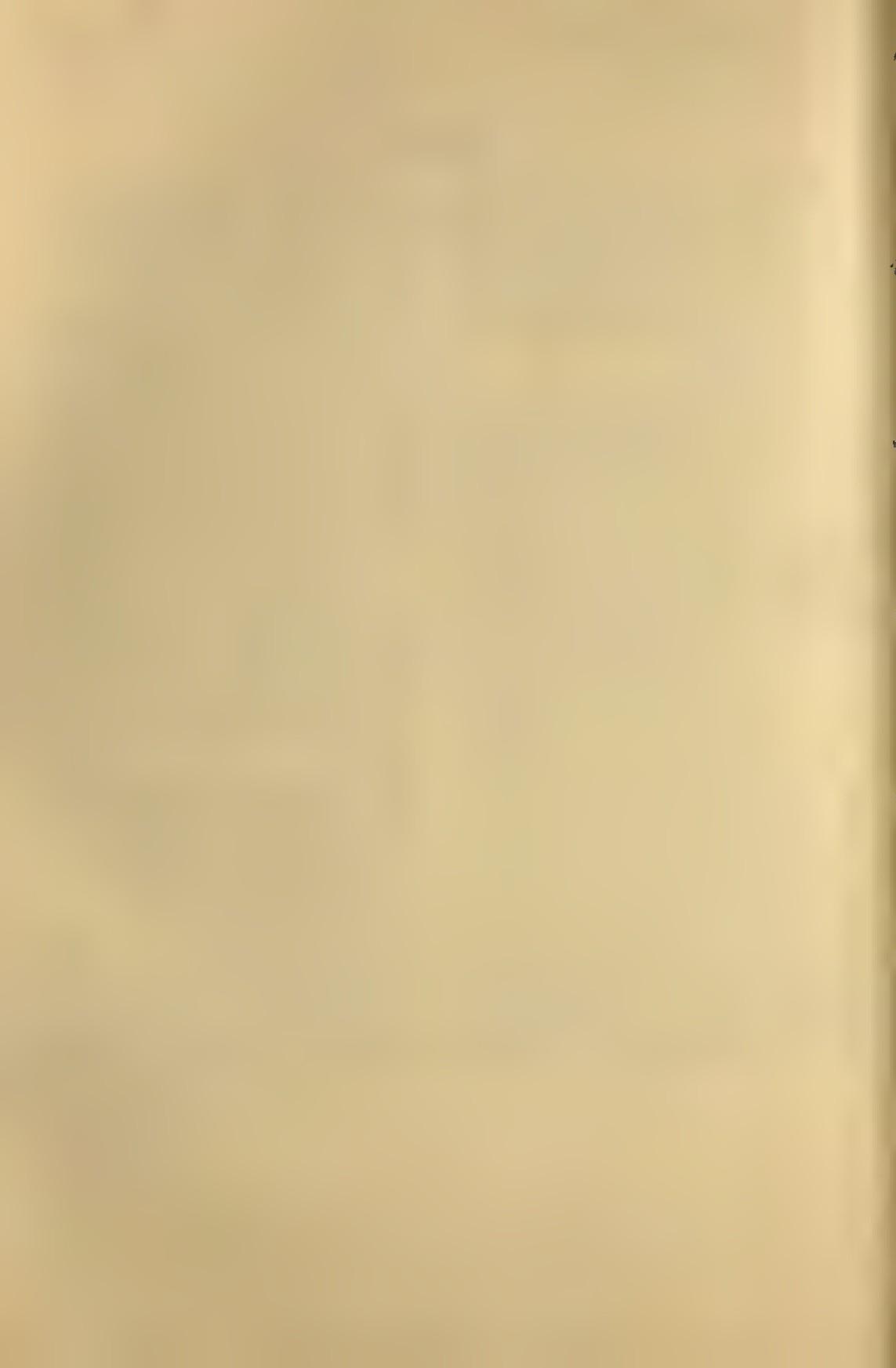
Reviews

Frustration and Conflict. By AUBREY J. YATES. (Pp. x+236. 28s.) London: Methuen. 1962.

This book is a review of experiments accumulated in the laboratory in the areas of frustration and conflict. It is not an exhaustive review of the subject; rather the concept of frustration is discussed in relation to such specific variables as fixation, aggression, regression, conflict, a chapter being devoted to each. The discussion takes the form of summaries of experiments, comments and theoretical observations, in a way that would make the book of interest to research workers and others with particular interest in this field of experimental psychology.

A feature of the book is the special attention given to the work of N. R. F. Maier. The writer considers Maier's work to be generally neglected and unappreciated, and sets out to improve the reader's awareness of Maier's important contributions.

It is difficult, if not impossible, to integrate the literature in this field of psychology, as in any other, under a unified system. A basic problem being that theroetical orientations diverge; the work of Lewin and his colleagues, for instance, taking quite a different slant from that of Maier or Hull, all of whom, and others, are brought into the discussion in this book. A possible outcome of such an attempt is that the person undertaking it risks emerging with a new system himself. This may be all to the good, except that, as the writer himself pointed out, the full implications of a particular system are not fully explored before they are discarded in favour of new ones. Avoiding this trap, the book, while containing some interesting hypotheses, does not claim to constitute an original contribution to theory.

Because of recent advances in the application of learning theory to the understanding and therapeutic handling of abnormal behaviour this book could be of significance beyond the general laboratory situation and be of use in generating clinical investigations. The chapters, however, do not suggest an awareness of this new significance. Perhaps, the final chapter on Frustration, Conflict, Learning Theory and Personality, in which certain hypotheses concerning what the writer sees to be the principal problems in the field were outlined, was meant to adjust this neglect.

B. GEO. BLAKE

Mosaic Patterns of American Children. By LOUISE B. AMES and FRANCES L. ILG. (Pp. xii+297. $9.50.) New York: Harper. 1962.

Those indefatigable co-workers from the Gesell Institute, Ames and Ilg, have, since the master's demise, turned their attention away from the child's perceptual-motor development and are now using the same approach for the study of personality growth as revealed by projective tests. Some years ago Ames published a book on Rorschach norms of childhood, and in the present volume it is the Lowenfeld Mosaic Test that is given the same treatment. The test results obtained from 100 normal American subjects at each yearly level between the ages of two and sixteen were most meticulously studied and analysed both quantitatively and qualitatively, and an outline thus presented of the developmental changes which were found within this age range.

It is good to see that some of the criticisms levied against the Rorschach work, such as small numbers and the neglect of longitudinal material, have been taken into account in the present volume. The old Gesellian language of the 1930's is, however, still retained: the almost magical power with which chronological age is endowed, the picture of development as progressing from one equilibrium to another, and the usage of such quaint phrases as 'successive reorganization of energies'. But a more serious charge that must be brought against the book concerns the limited applicability of its findings. No one will dispute the authors' point that the developmental component must be isolated from a child's test protocol before indicators of individual personality can be located, but the identification of this component involves the study of more than one highly specific sample. As Margaret Lowenfeld herself points out in the Foreword, the test is very susceptible to cultural factors, so that many of the

features found by her in the Mosaic patterns produced by English children apparently do not occur in those reported on the present sample of American children. The latter, moreover, are of superior status both intellectually (mean I.Q. 118) and socially (mainly from professional parents) and come from what is surely the most intensively studied and hence most psychologically sophisticated child population in the world, New Haven in Connecticut. In reading this otherwise very careful and commendable study it is therefore important to bear in mind (as the authors themselves do not always appear to have done) that extrapolation to other groups is not justified without further investigation.   H. R. SCHAFFER

Hospitals and Children: A Parents' Eye-View. By J. ROBERTSON. (Pp. 159. 18s.) London: Gollancz. 1962.

There are few areas in which psychological findings have had greater impact on social policy than in the field of maternal deprivation. The growing emphasis on prevention of mother–child separation, the introduction of the family-group system into many children's institutions, and the changes which may be observed in the organization of paediatric hospitals all testify to this influence. The changes, however, are often painfully slow to come. In paediatric circles in particular, despite the Platt report, despite official encouragement from the Ministry of Health, and despite the example set by some of the more advanced hospitals, much unnecessary suffering is yet encountered. Refuge is sometimes taken in the uncertainty that still exists in relation to the precise delineation of after-effects, particularly the more permanent ones, yet anyone who has ever observed the panic-stricken behaviour of a small child when left by his mother in a strange and frightening place just when, being ill, he requires her most, ought not to pause and ask about after-effects before becoming convinced of the urgent need to preserve the mother–child unit at such a time.

Emotions run strong on this issue, and rational conviction by a carefully designed research report has often proved far less effective in bringing about change than some other means of communication that can state in a dramatic form what separation from the mother feels like from the inside, as it were. Such a one was Robertson's film 'A two-year old goes to hospital', and his present book is of the same kind. It is composed of parents' letters telling of the experiences they encountered when their children had to be hospitalized. Sometimes these experiences were good, and Robertson is wise to put such letters at the very beginning of the book, but disturbingly often they were bad. The letters make engrossing reading, for they present their case effectively, graphically, and yet rarely immoderately. Robertson links them with just enough commentary to point out similarities and implications without unnecessarily intruding on the emotions that are so dramatically displayed. Most of the parents are full of praise for the medical and surgical care of their children, but in respect of psychological needs have often to report a callous indifference and ignorance that make harrowing reading. Unfortunate admission procedures, the refusal of hospital authorities to allow a mother even to see her child, the taking away of comforters and favourite toys, the sometimes quite brutal way of administering anaesthetics, and, perhaps worst of all, the ease with which mothers could obtain unlimited access to their children if only they went as private patients—that these can still be found in an age which prides itself on its concern for child welfare is often difficult to believe.

Just in one respect the book tends to be misleading. Coming mainly from the more educated and articulate section of the community, the letters give the impression that all parents are strong advocates of an open-door policy for children's hospitals and are only too anxious to obtain greater access. In fact, a considerable proportion of parents themselves still require convincing that they need not fear visiting and that it may well be better to sacrifice temporarily the welfare of other children at home in order to be with the sick one. The onus for education may be with the medical and nursing professions, but the issue is a more complicated one than a straightforward battle between parents and hospital sisters.

In general, this book strikes a most effective blow in the attempt to obtain for children one of their most fundamental rights, and should be read and pondered on by every paediatrician and children's nurse.   H. R. SCHAFFER

Contemporary Research in Personality. Edited by IRWIN G. SARASON. (Pp. 411. $7.00.) New York: D. Van Nostrand Company, Inc. 1962.

This volume contains a selection of forty-four research papers on contemporary personality research, which have already appeared in a variety of psychological journals. Although the papers are presented in nine separate sections, separately introduced by the editor, their content falls more naturally under four main categories. Sections I to III deal with personality testing and concentrate mainly on recent papers on personality questionnaires and projective techniques. Sections IV and V are concerned with personality development and the influence of social and cultural factors on different personality variables. In Sections VI and VII, the papers presented deal with studies of cognitive processes which have a bearing on personality theory and the last two sections are concerned with the examination and treatment of pathological deviations from the normal personality. It is difficult to make general comments on a book of this type which contains such an amount of diverse material and one tends to remember mainly those papers which accord with one's own interests. Another possible shortcoming of this type of presentation of previously published papers is that the reader invariably finds that the most impressive papers in the selection have already come to his notice at the time of their original publication in psychological journals. The material dealing with personality questionnaires does impress one with the painstaking attempts now being made to examine the results of paper and pencil measures of personality in a more critical manner, while the papers on projective techniques on the whole merely reemphasize the need for such critical assessment, rather than the means by which this might be carried out. The most original and stimulating contributions appear, to this reviewer, to occur in the middle sections dealing with personality development and the relevance of work on perception and learning to personality theory. Ian Stevenson, questions the assumption that infancy and childhood is a much more plastic and vulnerable phase of personality development than adulthood. This section also contains an interesting contribution by Lowell Kelly on the consistency of the adult personality

in a large group of married couples, followed-up over a period of almost twenty years. The section on cognitive processes contains a number of interesting papers, including a useful and critical review of work carried out on subliminal perception. From the point of view of clinical psychologists, the last two sections dealing with pathological deviations of personality are disappointing although they do contain a reprint of Frieda Fromm-Reichman's on the psychotherapy of schizophrenia.

In summary, this volume appears to be a useful addition to the library of those interested in keeping up to date with the multitude of contemporary research in the field of personality, and although the reader might disagree with the selection of papers, each reader will nevertheless find a number of the papers reprinted in this book are well worth reading, or indeed rereading.

ANDREW MCGHIE

Psychological Development in Health and Disease. By G. L. ENGEL. (Pp. 469. $7.50.) New York: W. B. Saunders. 1962.

This book has grown from the author's teaching to medical students in their second preclinical year at the University of Rochester, and should be considered in this context. Professor Engel does not intend his book to be solely an elementary text. He aims to provide a theoretical background to his preclinical teaching which may be re-read in the clinical years and again in post-graduate training, with increasing profit as clinical experience grows.

The first half of the book consists of a detailed theoretical account of human psychological development based on psychoanalysis. The development of the Oedipus complex and of object relationships are given extensive treatment. He attempts to relate these views to principles of general biology, with some additions from other sources. Piaget's work on intellectual development are considered, and in dealing with adolescence the views of Erikson and Anna Freud. There are few examples or case histories to illustrate the theories, but the omission is a deliberate policy, the author believing that such illustrations are best provided in clinical teaching.

The second part develops the writer's unitary concept of health and disease. Health and disease are considered as relative concepts, as 'processes

between and within the total organism and the total environment'. He deals with the relativity of the manifestations of disease and with disease as a failure of adaptation or adjustment. There follow chapters on psychological stress and the psychological responses to and consequences of it. Syndrome formation and nosological categories are examined in relation to these views.

The teaching aims of the Rochester scheme are well known. In a list of ten aims of psychiatric teaching given by Professor Romano—the author's colleague—the diagnosis of mental illness comes sixth. The psychiatric teacher is regarded as a co-ordinator of all disciplines, a preserver of unity in the midst of specialism. It is his task to develop the students' curiosity and perceptiveness, to teach patient–doctor relationships and to trace the development of concepts of health and disease. To achieve this, psychiatrists at Rochester teach both in a psychiatric department and in a medical-psychiatric liaison service. Much time is allotted to such instruction in every year of the curriculum: Professor Engel's classes in the second year alone occupy 120 hours. His book reflects the teaching aims of the course.

It is doubtful whether British teachers of psychology and psychiatry would make such claims for their subjects in medical education; it is certain that other members of the medical faculty would reject them. The main interest of this book is the light it casts, at times unwittingly, on the extent to which psychiatry and psychoanalysis have influenced contemporary medical education in the United States. Since British medical students do not receive the clinical and practical instruction necessary to complement a text of this kind, it cannot be recommended to them. Although it pays lip service to scientific method, it is too theoretical and gives insufficient attention to observation and experiment. Postgraduate students with psychiatric experience who require a comprehensive theoretical approach to mental development will find the book helpful, although they may be deterred by its wordiness.

I. M. INGRAM

The Phenomena of Depressions. By R. R. GRINKER. (Pp. 249. 52*s*.) New York: Paul B. Hoeber, Inc. 1962.

The authors present an account of a research programme in the phenomenology of depressions, which was commenced in 1954. Deploring the vagueness of the term depression, currently used, either as symptom, syndrome or nosological entity, they decided to investigate in an empirical way the symptoms and signs presented by a random series of patients admitted to the Institute for Psychosomatic and Psychiatric Research and Training of the Michael Reese Hospital, Chicago. The data obtained from 120 patients, 96 of whom sustained the broad diagnosis of depression, was processed elaborately by factorial analysis. (Of 242 pages, about 100 are occupied by symptom check-lists, tables of factor scores and other statistical matter.) This resulted in the development of a number of factors—five of feeling and concern, ten of current behaviour, and, combining the two sets, four factor-patterns or profiles—which for brevity might be labelled 'typical endogenous', 'agitated', 'hypochondriacal' and 'angry' depressions (though the authors consciously try to avoid using such over-simplified terms). They suggest that these factors are now available for correlation with demographic data, pre-morbid personality, type of onset, precipitating factors, amenability to various therapies, etc. They present the results as merely a first stepping-stone for further research towards reclassifying the depressions.

This book is essentially an interim report on a 'laboratory' investigation and as such must be of interest only to those engaged in, or contemplating, research along very similar lines. It is doubtful if the actual results will be of great value to workers in this country. (It is interesting that of the small number (96) of depressives studied, 60 were Jewish, 20 Protestant and 16 Catholic. The authors correlate religious groupings with various factors, but do not appear to think that this distribution of religious affiliations and, presumably, culture patterns, in the sample studied, calls for any comment.) Some incidental findings are interesting, though perhaps not surprising; e.g. the greater inter-observer reliability of residents and nurses compared with visiting consultants; and the near-uselessness of many case records for research purposes.

The difficulties in applying a strictly statistical and phenomenological methodology to a psychiatric syndrome are made painfully clear, and it is perhaps unkind to suggest that such heroic statistical labour deserved a larger sample.

J. W. MACPHERSON

Deprivation of Maternal Care: A Reassessment of its Effects. Various authors. *W.H.O. Public Health Papers*, No. 14. (Pp. 165. 10s.) Geneva: World Health Organization. 1962.

It is just over ten years since Bowlby's *Maternal Care and Mental Health* put the spotlight on maternal deprivation as an antecedent condition to certain forms of mental pathology. In the intervening period a great deal of work has been done on this problem: extending, criticizing, and further delineating the original hypothesis and in the process generating a great deal of controversy which at times has been rather marred by the highly emotional attitudes adopted by the participants.

Where stands the deprivation hypothesis now? A number of reviews have recently concerned themselves with this question, and in the present volume the World Health Organization has collected together the opinions of several individuals prominently associated with this topic. Some of the papers (such as those by Andry and Wooton) are merely a restatement of views already expressed elsewhere, while others (e.g. the paper by Prugh and Harlow on 'masked deprivation' and that by Margaret Mead on cultural aspects) concern themselves with specific issues only. By and large, it is a rather odd assortment of essays, differing considerably in approach, in scientific sophistication, in the level of conceptualizing, and even in sheer knowledge of the work that has been done. Thus it is rather depressing still to find the uncritical acceptance of some of the early studies that have since so severely been criticized, and to read of views attributed to Bowlby which he, in fact, never put forward. Under these circumstances the reader, hoping for an unequivocal answer, will be disappointed: most of the present authors seem to be firmly committed to either the *pro* or the *anti* camp, and their selection from the literature is accordingly biased. The identical studies are even quoted by different authors as supposedly either supporting or contradicting Bowlby's original formulations.

By far the longest paper (almost half of the monograph) is, however, devoted to the presentation of a more balanced view based on a very thorough and painstaking examination of the literature. In it Mary Ainsworth reviews the relevant studies in the light of the research strategy employed by them, contributes a most useful analysis of the concept of maternal deprivation, and formulates those problems which still require investigation. One conclusion which emerges clearly from this review concerns the terrific complexity of what may, at first sight, appear a fairly clear-cut experience. In fact so many variables define deprivation that it is perhaps not surprising that controversy and apparent contradictions are to be found. It is obvious that a great deal of work still needs to be done in addition to that which, thanks to the impetus of Bowlby's original formulation, has already been carried out. One can only hope that the studies of the next decade will be rather less concerned with issues of black and white, with whether deprivation always leads to permanent damage or not, and more with attempts to identify those variables inherent in this experience which may lead to a number of different outcomes.

H. R. SCHAFFER

Körperbau und Charakter, 23rd–24th ed. By ERNST KRETSCHMER. (Pp. x+463, illustrated. DM. 39.80.) Berlin: Springer Verlag. 1961.

This book summarizes all the German investigations of the relationship between body build and personality. The contributions of Sheldon and Tanner are briefly mentioned as supporting Kretschmer's general approach to this problem, but they are not discussed in detail. The book begins with a detailed description of Kretschmer's techniques of somatotyping. This is followed by a discussion of the correlation of body build with normal and abnormal physiological functioning. It then passes on to a detailed description of the temperaments associated with the different body types. This is followed by an interesting account of abnormalities of physiological and physical development. After this there are chapters on the results of psychological experiments in the different body types, the relation of crime and constitution and the constitution of men of genius. The book ends with a discussion of the author's theory of temperaments and types.

While it is possible to disagree with many of his views, there is no doubt that Kretschmer and his pupils have demonstrated a large number of correlations between body build on the one hand and personality, psychological functions, psycho-

somatic disorders and mental diseases on the other. This book is consequently of great interest to the psychiatrist, the clinical psychologist and the expert on psychosomatic disorders. It is therefore to be regretted that an important book of this size has been published without an index.

FRANK FISH

Psychological Practices with the Physically Disabled. Edited by JAMES F. GARNETT and EDNA S. LEVINE. (Pp. xi+445. $8.75.) New York: Columbia University Press. 1962.

Nowhere is the influence of the psyche on the symptomatology of organic disease more clearly demonstrated than in the field of rehabilitation. Early in this book, however, one is assailed by doubts about the wisdom of the present tendency of American rehabilitation teams to increase in size and complexity thus apparently fragmenting their functions. One forms an impression of the patient surrounded and bewildered by physicians, surgeons, psychologist, social workers, vocational counsellors and nutritionalists—to name but a few—each striving for perfection in their own discipline. That such a picture is false is suggested by the excellent results recorded. Nevertheless, the obvious fact might too easily be overlooked that very many people recover from or adjust themselves to the most serious organic disease with apparently very little external aid. Medical considerations apart, the extent to which this is due to premorbid personality, family support or other environmental circumstances is unknown and must await the result of much more research. Perhaps the most useful function of some of the present rehabilitation teams is the research now being conducted by them into just these problems.

This book is a symposium in which several well-known experts each contributes a chapter on the rehabilitation of a particular disorder ranging from rheumatism to deaf-blindness and cancer. It aims particularly at acquainting psychologists with an understanding of the purely medical aspects of the various diseases so that these can be more clearly separated from or understood alongside the related psychological symptoms. Each writer in turn rejects the concept of a personality peculiar to the disability considered, but concentrates rather on the specific psychological problems that arise. This leads to a certain

amount of repetition but as there are more ideas than real knowledge in this field, the different viewpoints tend to increase the book's value. The final chapter is outstanding for its approach to the general problem of motivation in recovery. Ample attention is given to the current literature and there is a comprehensive bibliography.

This is on the whole a well-conceived work raising many practical issues not readily found elsewhere.

It should prove of real value to anyone interested in the rehabilitation of the disabled.

L. H. COWAN

A Metascientific Study of Psychosomatic Theories and Their Application in Medicine. By CARL LESCHE. (Pp. 64.) Copenhagen: Munksgaard. 1962.

This short monograph is the tenth of a series of books, by different authors, the products of interdisciplinary discussions and studies of the Scandinavian Summer School since 1957. The author of this volume, Carl Lesche, is a Finnish psychologist. His declared purpose is to examine the problem of the explanation of psychophysiological relations. This he does by what he calls 'metascientific' analysis. Digressions into physics, mathematics and logic, intended to illustrate and clarify his theme, do not always achieve this objective. An outline of the relationship between pitch, frequency and loudness, an explanation of Newton's law of gravitation and accounts of other phenomena of physics, seem scarcely necessary to show that psychosomatics has no highly developed conceptual system comparable with physics. The need for logical thinking and adequate scientific evaluation in psychosomatic medicine clearly emerges from this book, but in a monograph which pays great attention to accurate semantics, it is surprising that no clear explanation is given of what the author means by 'psychosomatic', a term intrinsic to the theme of the book. The conclusion that there is at present no adequate explanation of psychophysiological relations is one with which most workers in the psychosomatic field would agree. However, the study of psychophysiological relationships is still in comparatively early days. It is a difficult field in which much research is going on. Is it not rather premature to expect at this stage a highly conceptualized psychophysiological explanation of

mental processes? Although it is short in length the reviewer did not find this book easy to read. It will be of greater interest to logicians than to psychosomatically orientated medical people.

DAVID M. KISSEN

Psychological Evaluation of the Cerebral Palsied Person. By ROBERT M. ALLEN and THOMAS W. JEFFERSON. (Pp. 86. $5.00.) Springfield, Illinois: Charles C. Thomas.

This little book of just over eighty pages contains a deal more than 100 references. The distinguished work of Allen in assessing intelligence in cerebral palsied patients is already well known, while Garret—who writes the introduction—has already carved a niche in history for himself with follow-up studies on workshops for the cerebral palsied. Both Allen and Jefferson of United Cerebral Palsy differ somewhat from the British National Spastics Society in defining cerebral palsy as 'the clinical picture created by injury to the brain, in which one of the components is motor disturbance'.

The authors have carefully examined and recorded their cases and reviewed much of the literature. A chapter on personality assessment is particularly good and something one does not find well written in most books of this size.

In the short chapter on vocational assessment issues, I would have liked more emphasis on follow-up. The passing reference to assay of patients' sensory and motor disabilities is in line with most other American text-books.

On the whole, the book shows evidence of having been carefully written, few mistakes are present and it makes pleasant reading. For British doctors working in the mental deficiency field it gives a succinct, snappy account of recent American work and it may be confidently recommended; for clinical psychologists in hospitals or units for the subnormal or spastic it is a 'must'.

RONALD C. MACGILLIVRAY

Perceval's Narrative: A Patient's Account of his Psychosis, 1830–1832. Edited by GREGORY BATESON. (Pp. xxii + 335 42s.) London: The Hogarth Press. 1962.

On 11 May 1812 the British Prime Minister, Spencer Perceval, was assassinated in the House of Commons. His widow and twelve children were granted a Government indemnity of £50,000 which helped to maintain the fifth son, John Perceval (1803–76) in private lunatic asylums when he became insane at the age of 27. On his release he wrote a long account of his experiences, now edited in one volume by Gregory Bateson.

Perceval had a conventional upbringing. After Harrow and the Army he went up to Oxford where he soon became interested in religion. After a few months at the university, he went to Scotland to investigate the Row Miracles. The devotees of this extreme evangelical cult (later called the Irvingites) spoke in an unintelligible gibberish as the spirit of the Lord moved them, and it is not surprising that Perceval's schizophrenic utterances passed unnoticed at their meetings. Still under the sway of evangelical notions, he crossed to Dublin where (if we are to believe his account) he promptly contracted syphilis from a prostitute. He then went raving mad. Violent, suicidal and completely dominated by his hallucinations, he was shipped to England under mechanical restraint, and placed in the private asylum of Dr Edward Long Fox at Brisslington near Bristol, where he remained for the next fourteen months at a cost of 300 guineas.

For nine months he was, on his own admission, in 'a state of childish imbecility'; and for as long as he obeyed his 'voices' Perceval was kept in full mechanical restraint. He was placed in a strait-jacket, and taken to a common room shared with a dozen patients. Here he was seated with arms manacled and feet fastened to the floor, whilst a strap across his abdomen secured him to the wall: he slept strapped to the bed and guarded by his personal attendant. Treatment was harsh and punitive. Violence was countered by a greater show of force from the attendants. Every morning Perceval was plunged head first into a cold bath: later he was given vapour baths, and had his temporal artery opened—all administered without any explanation from the doctors. He felt that he was having 'every feeling brutalized', and that he was not being treated in accordance with his 'situation, rank and character'. 'When I became insane', he complained, 'the knowledge of the fact appears to have given any one who had to deal with me *carte blanche* to act towards me, as far as seemed good unto himself, in defiance of nature, of common sense, and of humanity'. Occupational therapy included cricket, walks in

the grounds, and when he became more rational, occasional invitations to dine with the doctors and their ladies.

In May 1832 Perceval was moved to the asylum of Mr C. Newington at Ticehurst in Sussex where he was confined, in spite of an attempted escape, for eighteen months. After an acrimonious correspondence with the family he was given a private sitting room, and thereafter he began to improve. He reveals how he came to terms with his illness. He ceased to obey blindly the commands of his 'voices', although he could not, at first, completely disregard them. He noticed that by concentrating on external objects he could cause the 'voices' to be replaced by indistinguishable sounds; and he observed that the tone of the hallucinations varied according to his mood. He then realized that mistakes and misinterpretations arose from unconscious mechanisms, and he tried to relate his hallucinations to various perceptual errors such as after-images. When his brother lost a favourite dog Perceval decided to test the veracity of his 'visions'. He 'saw' a turnpike near a country inn, and suggested to his brother that the dog might be found there. But when the place could not be identified, he realized that he had been deceived by his hallucinations, and thereafter he came to disregard them.

On gaining his freedom Perceval immediately married. He broke off all relations with his family, and settled in Paris where he began writing this account of his trials. Did he completely recover? Unfortunately Gregory Bateson has been unable to assemble sufficient biographical data on which to base a sound judgement. But in 1859 Perceval gave evidence before the Select Committe for Lunacy on behalf of an organization calling themselves the 'Alleged Lunatics Friends Society' which raises suspicions that he may have still harboured paranoid delusions.

Bateson's introduction fails to provide a historical background to Perceval's narrative. The majority of early eighteenth-century alienists tended to adopt a scientific eclecticism with the main stress on unravelling the cerebral pathology of insanity. And in the same year that Perceval's doctor gave up general practice in Bristol and opened Brisslington Asylum, Mason Cox published his *Practical Observations on Insanity* (1804). Herein he postulated that madness was caused by too much blood to the brain, a hypo-

thesis evidently favoured by Dr Fox who tried to correct Perceval's hotheadedness with cold baths and blood letting from the temporal artery. Mechanical restraint was then used in every asylum, but in the year of Perceval's admission (1830), John Conolly first deplored its use, and eventually pioneered this humane reform. These medical details have a bearing on Perceval's experiences, and so too have the social and political conditions during his confinement. Delay in passing the Reform Act of 1832 brought the country to the verge of civil war, and Perceval mentions the fierce riots which broke out in Bristol when the proposed reforms were rejected. The asylum attendants showed their sympathy with the rioters by treating their wealthy and socially superior patients with less respect. Could Perceval, the son of a Tory Prime Minister and a supporter of the party opposing reform, really expect that the attitude of his servants (as he called the attendants) would remain uninfluenced by these bitter social struggles? Enlightened humanitarianism was not a feature of the Industrial Revolution.

Had Bateson attempted to fill in some of these historical lacunae he would have provided a more balanced introduction: instead he compares Perceval's treatment with present methods. This is superfluous, as several good contemporary accounts of institutional treatment, written by patients and exposing our present inadequacies, have already been published. Nevertheless John Perceval's courageous fight against mental illness, officialdom, and medical mumbo-jumbo makes an admirable narrative. But until society can rid itself of a sense of insecurity and feelings of self defence towards the mentally afflicted, then the institutional care of the insane may still be debased by harshness and neglect.

KENNETH DEWHURST

Fruition of an Idea. By MARTIN WAUGH. (Pp. 124. $3.) New York: International Universities Press.

This volume contains the addresses made at a scientific meeting held in April 1961. They celebrate the Jubilee of the New York Psychoanalytic Society and the Thirtieth Anniversary of the New York Psychoanalytic Institute.

The authors are Samuel Atkin, Bertram D. Lewin, Rudolph M. Loewenstein, Victor H.

Rosen, Heinz Hartmann, Leo Rangell, Lawrence S. Kubie and Jacob A. Arlow. In addition there is a foreword by Martin Waugh and a brief description by Burness E. Moore of the lighter side of the Societie's celebration.

Although noticeably suffering from some repetitiveness the different addresses throw interesting lights on the remarkable achievements of this enviable Society.

Perhaps the most remarkable has been its flexibility supported in its generous acceptance of the impetus of new talent from Europe in the thirties and forties and more recently in its continual self scrutiny in face of new needs and challenges.

The book is well set up with some photographs. Of special interest are three facsimiles of letters written by Freud in 1928. These are concerned with the practical arrangements for candidates seeking training with him at that time.

JAMES M. DAVIE

Freud: A Critical Re-evaluation of his Theories. By REUBEN FINE. (Pp. xii + 307. $6.95.) New York: David McKay Company, Inc. 1962.

Dr Fine sets out to do what his title suggests in a simple and unpretentious way. He is able to see Freud's faults and he shows them in their context beside his outstanding discoveries as a thinker and scientist. He points out that Freud was in many instances unable to admit to errors of judgement and oversimplifications. Freud later rejected many of these without stating so specifically, and this has led and still leads to confusion.

There are four sections. Part I deals with the historical background and Freud's early training and self-analysis. Much of the significance of his discoveries is lost if the state of philosophy and science at the time is not understood. This is therefore an important section.

Part II deals with Freud's first psychoanalytical system (1900–14)—the discovery of the Unconscious, the Libido theory, Transference and Resistance, etc. The reaction to Freud in some quarters, particularly to his theory of Infantile Sexuality, is discussed briefly. The author gives some explanation for the tremendous emotional loading which still exists both in the Freudian and anti-Freudian camps.

Part III deals with the development of Freud's 'second' system—the Id, the Ego and the Super-ego, etc. This section includes an account of Freud's revised views on Neurosis and Therapy, and a *résumé* of his works from 1914 to 1939.

Part IV attempts to place Psychoanalysis and Freud's contributions to psychology against modern psychiatry and psychology.

This is a strikingly clear and well laid out book. Dr Fine appends extensive critical bibliographical notes to each chapter.

URSULA S. JAMES

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THE
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BEING THE MEDICAL SECTION OF THE
BRITISH JOURNAL OF PSYCHOLOGY

EDITED BY
THOMAS FREEMAN

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W. RONALD D. FAIRBAIRN

Editorial

This issue of the *Journal* has the special purpose of honouring the distinguished psychoanalyst Dr W. R. D. Fairbairn. Dr Fairbairn has practised psychoanalysis in Edinburgh since 1924 and in consequence prepared the way for the development of psychoanalysis in Scotland. Through his writings he has exerted a profound influence on psychoanalytic thought in both Britain and abroad. The contents of this issue are contributed by those who have had direct contact with Dr Fairbairn and by those who believe that his theories have influenced and widened their clinical and theoretical views.

This brief introduction is best concluded by the following tribute from Dr J. D. Sutherland.

'It was a very special pleasure to me to prepare a paper under the stimulus of paying tribute to Dr Fairbairn. The intellectual debt of many of my colleagues and myself to him is a large one. Much of the work done by the "Tavistock Group" during and since the last war has drawn on his theoretical clarifications. For myself there is a much greater personal bond. I was one of his first pupils and the heartfelt remark that I should like to make on this occasion is to say that it is to him that I owe my whole career in psychiatry and psychoanalysis. Only those who were close to him during the earlier years of his psychoanalytic work can fully appreciate the situation in which he had to struggle for psychoanalysis—the isolation and, at times, persecution that he had to endure. Many psychotherapists all over the world will enjoy the homage that this number of the British Journal of Medical Psychology in his honour pays to him. To those few who were close to Dr Fairbairn in the past, it brings a particular satisfaction.'
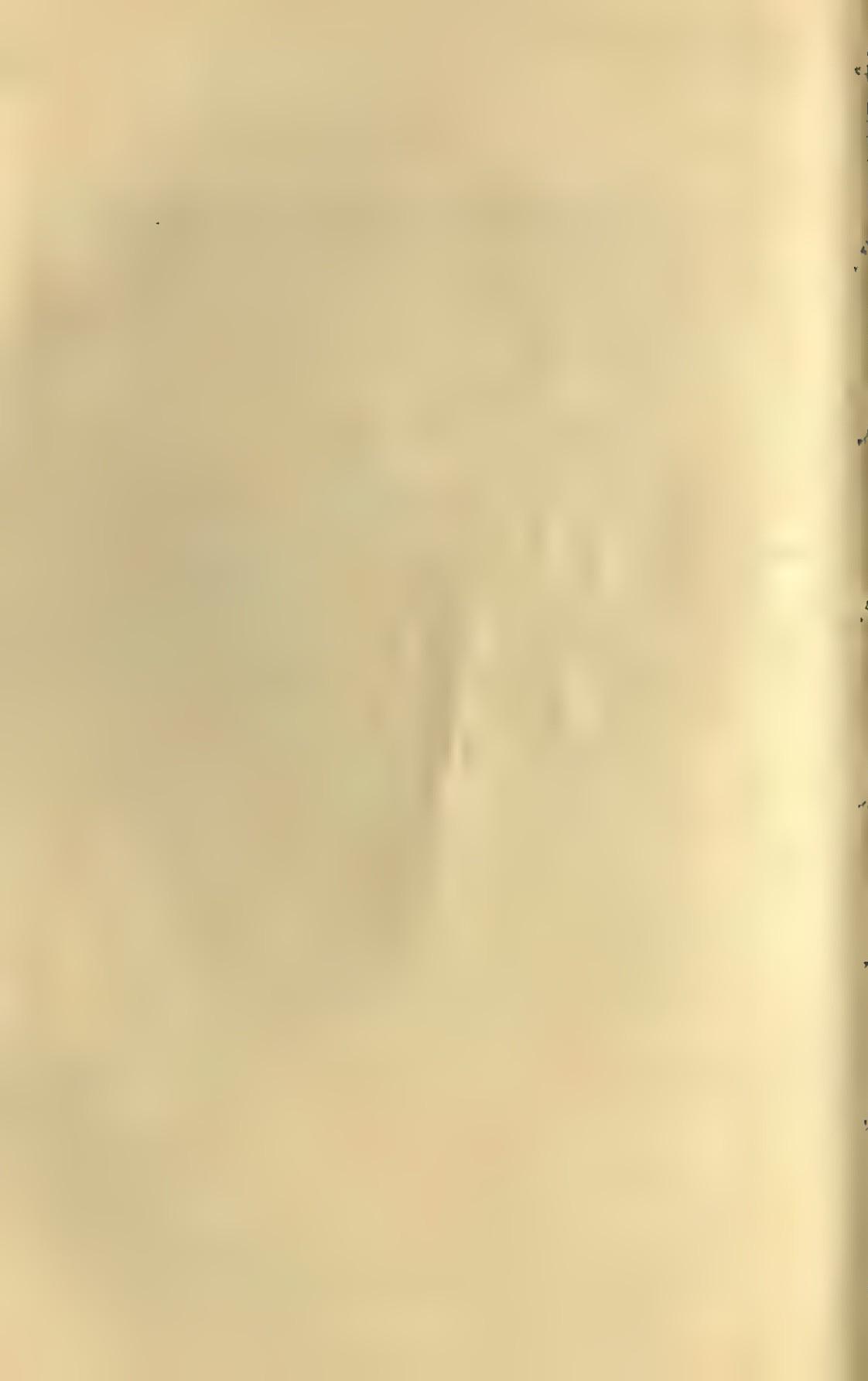
Autobiographical Note

By W. RONALD D. FAIRBAIRN

I was born in Edinburgh on 11 August 1889; and I have lived in Edinburgh for most of my life, although from 1941 to 1957 my home was at Gifford in East Lothian. It will be noted that I was born during the reign of Queen Victoria; and I have retained considerable affection for the Victorian régime, which has been subsequently so much maligned, and, as I think, misrepresented. I had no objection to going to church on Sunday mornings; but I disliked Sunday afternoons when ordinary activities were suspended and there seemed to be nothing to do. During the Victorian period I was accustomed to see working class children going about in the streets in bare feet—which was not so good; but life in the streets was much more interesting then than it is now. For example, there were German bands, barrel-organs, one-man bands, performing bears and Punch and Judy. Vehicles were all horse-drawn, of course; and there was the periodical excitement of seeing horse-drawn fire-engines dashing along the street with the horses galloping and smoke and flames bellowing forth from the chimney of the fire-engine—an impressive sight.

My early education was obtained at Merchiston Castle School, Edinburgh. I started in the lowest class in the Preparatory School and ended in the top class of the Upper School. So Merchiston Castle was my only school. After leaving school I went to Edinburgh University, where I took the degree of M.A. with Honours in Philosophy in 1911. My original intention had been to become a lawyer; but my study of philosophy had the effect of imbuing me with more idealistic notions. The result was that I devoted the next three years to the study of Divinity and Hellenistic Greek. During this period I studied not only in Edinburgh, but in the Universities of Kiel, Strasbourg and Manchester. Then came the First World War, during which I served as a Territorial in the Royal Garrison Artillery. To begin with, I was stationed on the Forth defences; but, after volunteering for service overseas, I served in Egypt and Palestine under General Allenby. During the Palestinian campaign I took part in the capture of Jerusalem; and I actually spent Christmas Day, 1917, in Jerusalem, where my battery had a gun-position at the time. During the course of the war, I decided to go in for medicine with a view to specializing in psychotherapy; and after demobilization I entered the Medical Faculty at Edinburgh University. After a somewhat abbreviated course I obtained the degree of M.B.Ch.B. in 1923; and in 1927 I obtained the qualification of M.D. I also obtained the Diploma in Psychiatry at Edinburgh University.

After obtaining my medical qualification I was Assistant Physician at the Royal Edinburgh Hospital for Mental Diseases from 1923 to 1924. Thereafter I began psychoanalytical practice in private; but I combined this practice with various appointments. Thus from 1926 to 1931 I was Assistant Physician at the Longmore Hospital, Edinburgh; and from 1927 to 1935 I was Lecturer in Psychology at Edinburgh University. I was also Lecturer in Psychiatry from 1931 to 1932. At the same time I was Medical Psychologist at Jordanburn Nerve Hospital, Edinburgh, and at the Edinburgh University Psychological Clinic for Children from 1929 to 1935. During the Second World War I was Visiting Psychiatrist at Carstairs E.M.S. Hospital from 1940 to 1941. Thereafter I became Consultant Psychiatrist to the Ministry of Pensions—a post which I held until 1954. During all this time and subsequently, I continued psychoanalytical practice in private. Two years ago I virtually retired; but I still have a few old patients under analysis.

I am not quite sure exactly when I was elected to Associate Membership of the British Psycho-Analytical Society; but I think it was in 1931. A few years later I was elected to full Membership.
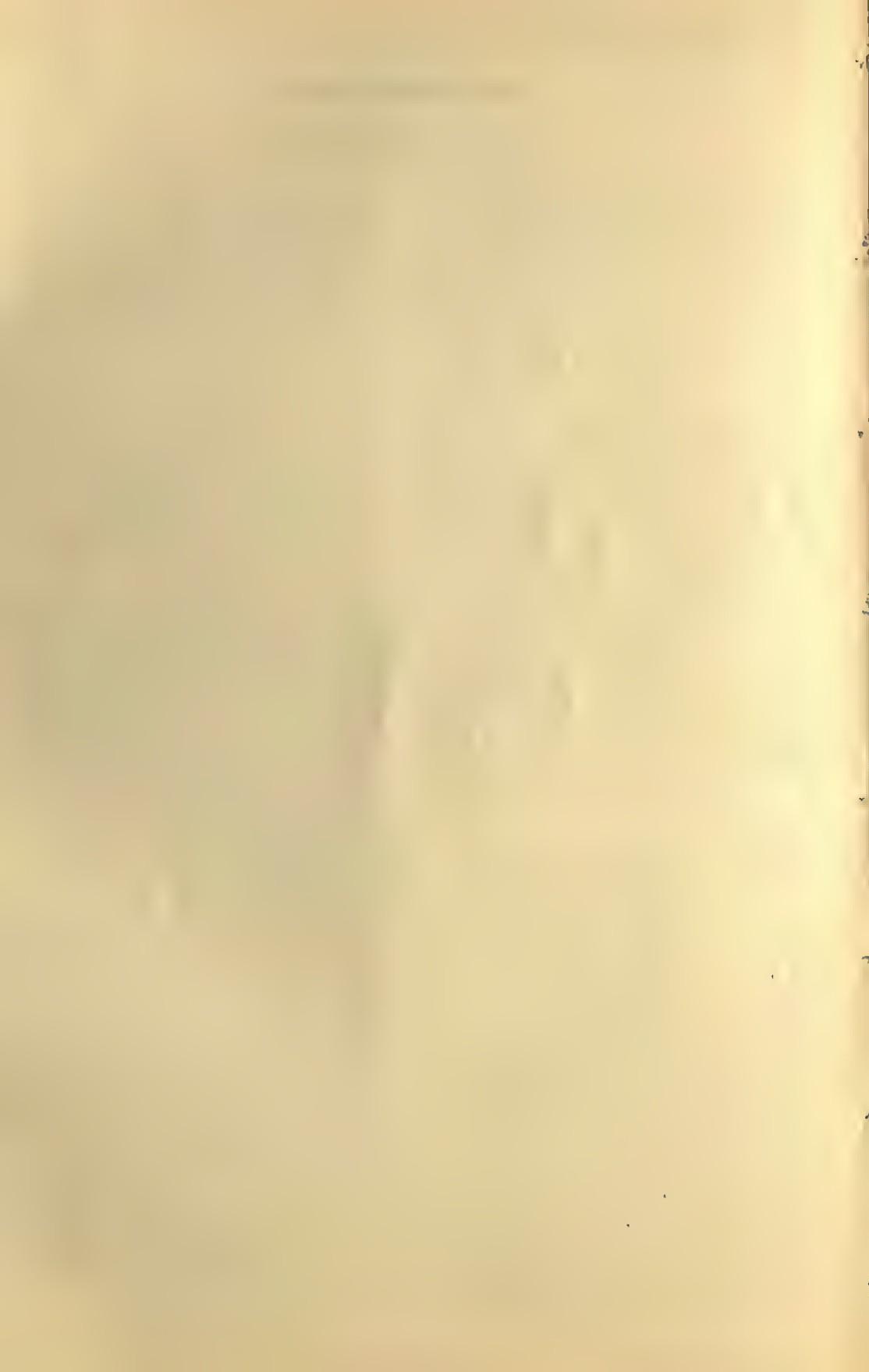
Object-relations theory and the conceptual model of psychoanalysis*

By J. D. SUTHERLAND†

In recent years there have been two prominent areas of development in psychoanalytic theory:

(*a*) The advances in ego psychology, in which Hartmann, Kris, Lowenstein, and Rapaport in the United States and Anna Freud in the United Kingdom have played a leading part.

(*b*) The work on the role of object relations from what has been called loosely the English school. Although deriving in large part from Melanie Klein, these views have had major contributions from British analysts other than Klein's associates, e.g. Fairbairn and Winnicott.

To British analysts it is striking how far apart these two areas of work have remained. (For some years it seemed that the work of Klein had been declared an un-American activity!) There are now signs that this situation is changing. I believe this trend is due to a growing realization that some of the apparent differences do not represent incompatible lines of work, but, on the contrary, can be seen in substantial measure as complementary. In what follows I propose to make use of the conceptual models that have been developed as a result of the theoretical work in these two areas to focus attention on where some of the differences lie and so help to promote a fruitful interchange of viewpoints.

In his book, *Energy and Structure in Psychoanalysis*, Colby (1955, p. 79) prefaces his description of his model of the psychic apparatus with some observations on the status and function of models. Models represent one method of describing the parts of a whole and their organization. They are 'visual aids, but they picture only imaginative constructions of organization'. Further notes of caution are sounded when he points out that, although they do not constitute a theory but merely help to illustrate it, they are often mistaken for the realities of which they are representations.

The complexities of the massive body of observations and constructs which now characterize psychoanalysis make it most unlikely that any one model would cover other than limited aspects of its theories, and this is probably one of the reasons that have led psychoanalysts to prefer verbal descriptions of their theories. Nevertheless, the *fons et origo* of psychoanalytic theories, the psychoanalytic process, has universally accepted features which readily suggest the use of models. Karl Menninger (1958), in one of the recent books on this theme, *Theory of Psychoanalytic Technique*, finds a working model of the way in which psychoanalytic therapy operates as a helpful device. The position may be put more strongly. Psychoanalysis is a long-term process which is set in motion deliberately by the analyst. He assumes that only through it will the patient get the necessary conditions for achieving certain changes in his personality functioning. Moreover, the analyst expects to control this process in substantial measure by his activities. A statement in the form of a model, or quasi-model, of the concepts used in the theory and practice that underlie his controls is a necessity if assumptions are to be adequately scrutinized and checked, and hence greater power and precision achieved.

The requirements Colby lists for a model of the psychic apparatus can be taken as a starting point. For him a model should:

(1) distinguish the variables of primary im-

portance from others which are secondary or
derivative.

(2) show how internal biological conditions
are integrated with the external environ-
ment.

(3) allow for maturation and experiential
development.

(4) provide for individual uniqueness and
societal variations.

(5) indicate how it works.

Of this list, the first one contains the crux of
the matter. What are the *variables of primary
importance*? I believe it is the failure to get
these right rather than the complexity of the
data that has led to the neglect of conceptual
models. Most psychoanalysts have found the
models put forward so far to have only limited
relevance to their practice, and for those with
more theoretical interests, the awareness of
the gap between theory and practice has con-
firmed their lack of enthusiasm for them.

In considering the applications of Hart-
mann's development of psychoanalytic
thought Rapaport (1960, p. 125) notes that
the essential task of studying a relationship
between an explanatory theory and the method
of observation by which the data are obtained
is rarely pursued. 'We need to know, for
instance, to what extent does psychoanalytic
theory reflect human nature and to what
extent does it reflect Freud's methods of
studying human nature?' He then goes on to
state that the psychoanalytic relationship . . .
may well require a distinction to be made
between ' . . . a *general* psychoanalytic theory
which is little dependent on these methods,
and a *specific* psychoanalytic theory which is
greatly dependent on them'.

It is abundantly clear that in Rapaport's
writings as he himself states, he focuses on
those aspects of the theory which are not
obviously dependent on the clinical method
and tries to avoid concepts which obviously are
tied to them, like transference, interpretation,
etc. A noteworthy instance of this divorce
from the clinical findings occurs in Rapaport's
earlier paper (1951) on 'The conceptual model
of psychoanalysis'. ' . . . for reasons that lie

beyond the scope of this paper I will not deal
here with the relevance or irrelevance of this
model to phenomena which are variously
referred to as those of conscience, ego ideal,
superego, etc.'

I believe that some of the differences in the
two areas of work may be related to this
apparent greater distance between clinical data
and theory in the ego-psychology group as
compared with the British workers. To quote
Rapaport again (op. cit. p. 84). 'When the
rules of thumb of clinical psychoanalysis are
equated with the theory of psychoanalysis, the
observations and concepts which bridge the
gap between the basic concepts and the initial
observations are inevitably overlooked'. What
to my mind is the most important part of this
observation is the phrase 'the rules of thumb'
because it indicates that the psychoanalytic
method for him is a rather haphazard one from
the scientific point of view. Rapaport further
notes that. 'The psychoanalytic writer and
practitioner is inclined to speak of psycho-
analytic concepts and theories in terms of
"content".' He then adds that ' . . . while
content is an important "*guide*" to the practi-
tioner, the majority of contributions to the
literature tend to dwell on content to the
neglect of other guides'. 'What is lost sight
of and the practitioner need not necessarily
keep this in focus or even in sight, but those
interested in theory must is the functional
(and thus also conceptual) relationship *to
which* the content is a guide . . . No content
yields its full meaning unless its formal charac-
teristics, and those of the time, place and
context of its appearance, are taken into con-
sideration, that is to say, abstracted . The
stress on content seems to be one of the main
causes for overlooking the relationship
between concepts and observables.'

Much of this structure is arresting to the
psychoanalyst brought up in the tradition of
the British School. For him the distinction
that is being made between the content and the
formal relationships would not exist, because
the focus of his attention all the time is the
study of the relationships going on between

himself and the patient and to these content is only one guide. For him, too, clinical data are the foundations on which psychoanalytic theory rests. He therefore views theories not closely related to these with reserve; and with regard to the method, he would not accept its status as at the 'rule of thumb' level.

THE CLASSICAL CONCEPTUAL MODEL OF PSYCHOANALYSIS AND EGO PSYCHOLOGY

The classical model of psychoanalysis appeared nearly forty years ago when Freud formulated his structural concepts. The ego was the part of the personality concerned with organizing the adaptation of the person to the external environment, regulating the means by which he sought satisfaction for his drives (the id) and reconciling these with a more primitive control system (the superego) which operated unconsciously within the ego. These structures were finally shaped by the experience of the Oedipus conflict according to the first formulations. This theory permitted a considerable advance in psychoanalytic understanding and consequently produced a fresh mass of observations from the widened range of conditions it enabled the psychoanalyst to treat more comprehensively. It seemed to give a foundation for so much that had been obscure, especially the unconscious sources of resistance and guilt. It led to an interest in the structural parts of the personality, the ego and the super-ego, and to an understanding of how the ego was patterned by its defensive needs. The development of the ego in its earliest phases became increasingly important, a trend related to the fact that data from the neuroses gained in width and depth and also to the new findings of child analysis.

Freud's view of the id as a reservoir of un-organized drive energies with the structured ego and super-ego trying to regulate their discharge was gradually perceived as an over-simplification. Hartmann began to publish his well-known series of papers, many his own and others with associates, on a new concept of early development according to which the ego and the id were differentiated from the first undifferentiated phase. The ego was structured not only by the experiences of the infant and young child in the satisfaction and frustration of its drives, but also by the maturation of autonomous ego capacities, e.g. motility, perception, etc. As part of these developments Hartmann took psychoanalysis to be no longer a theory restricted to conflict or to unconscious processes but a general psychological theory. His additions, however, to the theory of ego development and the concept of autonomous ego do not alter basically Freud's model. For him, the id still derives from libidinal and aggressive energies.

The value of Freud's model in relation to the clinical phenomena is obvious enough and so it should be since the component parts were postulated to account for clinical phenomena. On the other hand, the ego-psychology group have tended to regard some of the conceptual usages and developments from these theories, e.g. the super-ego, as anthropomorphic notions. To quote from Rapaport again, 'In clinical parlance (and even in the theoretical writings) of psychoanalysis, the explanatory concepts are anthropomorphized, reified, or at best presented in existential terms giving the impression that they refer to entities, or at least that each of them refers to a specific behaviour. But this is not consistent with the theory. The tendency to anthropomorphize and reify, and the preference for hypothetical constructs, probably derives from clinical practice, where there is a premium on the "plausibility" and "uncomplicated everyday application" of concepts.'

There has certainly been a massive move here from what Brierley (1951) has described as the personological level of description to the terms of process theory. Guntrip (1961) in his recent book has dealt with some of the implications of this move at length and I shall not devote any attention to it other than to summarize by saying that herein lies the critical issue. In Rapaport's model he combines three primary models designed to explain action or conation, ideation and affect, each of which

was formulated early on by Freud. He then has to outline secondary models which are concerned with the development of derivative drives. 'In contrast to the primary models, all the secondary models involve structuralized delay, that is to say, progressive, hierarchically layered structure development. The structures in question are: defence and control structures, structures which segregate affect charges, and the means structures which subserve secondary action—and thought-processes. A parallel development takes place in the hierarchy of motivations; each step in structure development results in a delay imposed on motivations which in turn gives rise to new derivative motivations and affects. The multifaceted hierarchic development is the development of the ego, and involves the differentiation of the ego from the id, and the super-ego from the ego. The id–ego–super-ego trichotomy is the broadest structural articulation of the mental organization and, as such, a crucial conception of the clinical theory of psychoanalysis. Since it can be derived from the models discussed, it is not an independent model and we shall not dwell on it here.'

The critical issue as Guntrip (1961, p. 136) brings out in his discussion may be put this way. While it is true that the eventual organizations which are at the top of the hierarchy can be derived from previous processes, in what sense are we to accept the earlier processes as the primary variables which Colby stipulated as the first requirement in a model? Here we are up against a familiar problem in biological thinking, of the extent to which one may lose sight of essential qualitative differences that supervene at the higher levels of organization by relating these complex phenomena to variables appropriate to lower levels. It is not of course that Rapaport is ignoring this problem. For instance, after noting the steps in psychoanalytic theory in a discussion of the structure of the psychic system from the adaptive point of view (op. cit. p. 57) he goes on to say that a fifth conception of reality, which was foreshadowed by Freud's third conception and Hartmann's, is the psychosocial one developed by Erikson. 'Man is potentially pre-adapted, not only to one average expectable environment, but to a whole evolving series of such environments. These environments to which man adapts are not "objective", but rather social environments which meet his maturation and development halfway: social modalities (e.g. the socially accepted forms of "getting") foster, select and harness his developing modes (e.g. the incorporative oral mode) of behaviour (Erikson, 1950). This is the genetic counterpart of Hartmann's systematic formulation; it is thus far the only attempt to conceptualize the phases of epigenesis through which pre-adaptedness becomes effective, and in which processes of adaptation inseparably unite behaviour epigenesis and environmental conditions.' For Rapaport, however, the inclusion of the psychosocial point of view is a mark of systematic weakness, since it is merely a specific aspect of the adaptive point of view (p. 65). He states that '...Hartmann's and Erikson's theories are too new, their implications too little understood and their relationship to each other too little explored to permit a statement disregarding all but systematic considerations'.

In short, therefore, the main theoretical trend deriving from the work on ego psychology has thus far led to a concentration on rather limited concepts for the functioning of the personality. Although the relatedness of the ego to the other parts of the personality is constantly acknowledged amongst the ego-psychology group, the failure to do justice to the structuring in the other parts, especially in that area covered by the term 'the id', has led to the development of concepts that perpetuate, or even increase, a divorce between theory and clinical practice that many analysts have recognized in recent years. One of the main features in ego psychology seems to be a need to formulate theories in terms that are thought to be more appropriate to science, or more accurately, to other scientists. For analysts, however, as for others, theories must be closely linked to their practice, and the data of

psychoanalysis do not lend themselves to too much depersonalization.

THE OBJECT-RELATIONS MODEL

The most radical statements of object-relations theory in Great Britain, those of Fairbairn, and the detailed expositions of Fairbairn's theories, together with his own contributions by Guntrip, adopt a completely opposed standpoint in trying to create a model which operates in a way that can be directly related to clinical data and social interaction. This move in the direction of adopting more 'anthropomorphized' structures, i.e. structures which do justice to the phenomena of inter-personal relations, would also appear to be a direct development of the last major trend in Freud's work, viz. the structural theories and the introduction of the super-ego. It is not, as I suggested earlier, a development incompatible with the ego-psychology work, but a development on a more comprehensive front and one into which the ego psychology work can, I believe, be fitted.

Several developmental trends in Great Britain have contributed to a particular interest in the structuring of the personality from the very start in terms of the relationships between the infant and its environment. Balint (1952), stimulated by Ferenczi, was one of the first psychoanalysts to make a definite pronouncement on the primacy of object relations. Using observational data from the feeding interaction between mothers and young babies, he linked his inferences from these with the findings from child analysis, the study of psychotics and the greatly enriched data coming from the psychoanalysis of the neuroses following developments in the use of the transference consequent on Freud's structural theory. The work of Susan Isaacs, Middlemore and Winnicott and others reinforced this trend.

It was Klein's work, however, which eventually impinged more widely, more profoundly, perhaps because she was the first analyst to make full use of the extraordinary richness and complexity of the phantasy lives of young children. Moreover, whatever reactions her theories may have aroused, there was no question of her data being too much the product of her method because children's phantasies can be studied in considerable detail without analytic intervention provided the observer is prepared to spend time with a young child. Such manifestations required the postulation of a relatively high degree of structural development at early stages.

Klein and her co-workers suggested that from the start of extrauterine existence the painful affects of frustration and the intense aggression associated with these feelings led to the creation within the psyche of developing 'imagos' of the early objects. At first the breast was predominant, but the internal objects rapidly extended to the whole of the mother's body and her person. These structures evoked within the child the same feelings of persecutory relationships as had the external object. Alongside these persecutory imagos, there are also being laid down imagos of the good breast-mother.

According to Klein, these inner objects are very real and concrete in the experience of the child. The ego grows in active relationship with them and its successful development is governed by the intensity of the affects in these internal relationships. Much controversy has been engendered on the nature of these internal objects and their role. Because of the concrete qualities she attributed to them, many analysts have felt there was a strong anthropomorphic tinge about Klein's theorizing. Nevertheless, it does not seem that there is anything improbable or unpsychological about such internal imagos developing from the earliest stages, or that these imagos should play a dynamic role. As Brierley, one of the most careful and objective writers amongst British psychoanalysts, puts it, there is no real difficulty in conceiving of an embryonic 'imago' of the object from the start because of the different feelings that must be present when the object, e.g. the nipple, is actually present (op. cit. p. 50). What is of fundamental im-

portance is the function of this inner imago or object. As a built-in part of the relationship between the infant and the object, it appears that it can be used as the object itself—cp. Freud's hallucinated object—or as part of an object-seeking system in which it patterns the perceptual organization. This latter role is what Klein describes as the projection-introjection system of object-relations development. That is to say, outer objects tend to be perceived and responded to in terms of inner ones. Normally, however, the outer objects do not behave as badly as the inner ones. When the former are introjected again they are therefore less persecuting; social leaning occurs.

When the affect within the relationship system is too disturbing, the inner objects become too frightening to be used in this projection-introjection system. Relations with the outer world can become seriously restricted. Such systems are then split off within the psyche from the central one in which the transactions with the outer world are proceeding apace. The systems which get segregated retain their bad objects and because of the latter being relatively unmodified by the transactions with the real objects, the frightening qualities of these inner objects remain governed by the primitive affects and phantasies. The internal bad objects for Klein are the precursors of the super-ego and the severity of super-ego persecution in many patients, adults and children, supports her view that these structures must have been laid down in very early stages.

The range of inner objects created within the psyche means that the child in Klein's view has an inner microcosm in which strong affective relations with inner objects, good or bad, are the fundamental feature. The child's play and most of its developing cognitive and socially adaptive capacities are determined by these inner relations.

The full implications of Klein's observations and formulations for some of the classical theories of psychoanalysis were not followed through by her, and it remained for Fairbairn

(1952*a*) to point these out in a series of papers beginning in 1940. Although expressing his indebtedness to Klein's views on the importance of inner objects, Fairbairn developed his own ideas in complete independence. The starting point of his thinking was the nature of the difficulties presented by schizoid patients. It has long been known that these patients have pronounced difficulties in their social relations, but what had not been recognized, according to Fairbairn, was the extent to which their inability to make satisfying personal relationships appeared to be the root of their troubles. Moreover, he asserted on the basis of his clinical experience that underneath the symptomatic differences between the various psychoneurotic conditions, there was a severe schizoid problem.

To account for the phenomena of the schizoid disorders, Fairbairn was led to the view that it is the relationship with the object and not gratification of impulse that is the ultimate aim of libidinal striving. The *cri de coeur* of all his patients, he concluded, was for a loving mother or father, and not for the quenching of more limited tensions. In keeping with this longing, the main features of the schizoid patient are defences against the painful affects of not being loved by a parent figure with full acceptance. The conflicts within the primary relationship of the infant and its mother lead to a splitting off or segregation within the originally unitary ego of the intolerable aspects of the relationship. Such a split involves a division of the pristine ego into structures each of which contains (*a*) a part of the ego, (*b*) the object that characterizes the related relationships, and (*c*) the affects of the latter. Fairbairn therefore proposed that the libido theory in its classical form and the concept of unorganized id should be replaced by concepts of dynamic structures derived from a psychology of object relations.

Revisionists of Freud's theories have often been castigated for their failure to give systematic form to their views, and to state how their revisions affect psychoanalytic

theory as a whole. It is also commonly said of them that they do not grasp fully psychoanalytic theory. A careful appraisal of Fairbairn's writings removes the grounds for any such criticism being applied to him. He writes with admirable lucidity and reveals the close relationship of his own views to those of Freud. Thus, in his paper on 'The repression and the return of bad objects' (1952*a*, p. 61) he shows in Freud's own writings how the nature of the repressed can be related to objects. Freud had noted that as well as the internalized relations between the super-ego and the ego (the relationship of the ego to its 'good' internalized objects), the super-ego also represented an energetic reaction formation against the earliest object choices of the id. The significance of this statement, as Fairbairn points out, is surely to imply that the repressed will be concerned with the relationship of the ego to 'bad' internalized objects.

Fairbairn has given an outline of the development of object relations from the dependence of infancy to the mature relationships of later stages. The fact that he has not filled in this development in detail is of little consequence, for the conceptual model of adult behaviour which he developed readily permits Colby's requirements to be met. Guntrip has described Fairbairn's final model (op. cit. cp. xv) and here it is only appropriate to note its main features. These are:

(1) a central ego in relation to an ideal object directly repressing the following structures:

(2) an antilibidinal ego related to the rejecting object (sadistic primitive super-ego); and

(3) a libidinal ego related to the exciting object.

The repression of this latter structure is further re-inforced by (2).

These structures are conceived as interrelated dynamic psychological systems, constantly in active relationship with each other and with the outer world. Each structure has a great complexity in depth into which is built its history. The particular experiences of the person will contribute many subsystems which could, for instance, be precipitates of repressed relations at the oral, anal or phallic phases of classical theory; but there is a tendency for these constituent subsystems to group or to assume a hierarchical order around the image of one person, even if only loosely. The first manifestation of a bad object relationship in the course of analysis may therefore centre around one or other of these subsystems, but as the analysis proceeds all the components come to the surface.

Fairbairn has retained the adjective 'libidinal' to describe the object-seeking tendency of the person. I think his libidinal ego might be more accurately described as the repressed or rejected libidinal relationships, for while it is true that the repressed needs are libidinal in character, not all libidinal relationships are 'outside' the central ego.

To minimize the intrusion of possibly confusing theoretical stereotypes I propose to put what I take to be the essence of Fairbairn's conceptual model into a series of statements and propositions. Many of these are about behaviour or at a first level of abstraction from the kind of phenomena met with in human relations in general and in psychoanalytic relationships in particular. Where they contain inferences about the nature of underlying processes I believe these inferences can be clearly recognized.

(1) The person is related to his social environment by means of a number of dynamic psychic structures or systems which vary greatly in the degree to which they are in open transaction with the social environment.

(2) The word 'systems' indicates that these structures are organized and seek to effect certain kinds of relationships. By the term 'transaction' is meant an ongoing relationship in which there is a *reciprocal interaction*. Each person is involved in such relationships in an active way with his or her needs constantly affecting the behaviour of the other and vice versa.

(3) Systems vary in their mode of activity and in their topological position within the

personality as a whole. They fall into two important groups:

(a) Those which are felt to belong to that part of the self the individual wants to be. These come within a central organizing structure (the ego).

(b) Those which are split off or repressed from this self or central system. (The words split, repressed, dissociated, or segregated are used interchangeably in this context.)

The central system, or ego

(4) This system has assimilated and organized much of the experience with significant people in the early environment and hence much of the cultural pattern in which the individual is reared. This central organization (the ego) is characterized by its relatively much greater capacity to learn and by its unique feature, namely that its integrative functions appear closely connected with consciousness.

In the healthy adult, the main needs are sufficiently ego-syntonic and of such a character that a manifold set of personal relationships is sought and maintained. The relatively free transactions between the need systems themselves (greater communication) in the healthy person also means that he responds more as a whole, is more integrated in assessing inner and outer reality. The central ego in such a person is therefore being enriched throughout life and this *constant enrichment provides a motivational growth and support*.

Typical of the healthy or strong ego are this freedom of communication between different need systems and the consonance of the main needs over time.

The whole question of the scale and the maturational phases of developments in the human personality is something which only Erikson (1950) has attempted to encompass. Although Fairbairn discounts instincts in the sense in which they have been commonly used in psychology and psychoanalysis, the work of the ethologists has shown that a more flexible and illuminating approach to the instinctive roots of behaviour can be made, particularly in regard to social behaviour and object relations. Bowlby has made a major contribution in this direction concerning the nature and development of the attachment of the child to his mother. The tie between the reproductive pair is almost certainly mediated by a number of response and need systems which allow for the rearing of the family over time. It is this kind of approach which could lay a biological foundation more in keeping with the need for sustained object relations than is the primary model of drives and their tensions conceived so often in hydrodynamic terms and requiring so many derivative structures for the social behaviour that is basic to human survival.

The development of the relationship of the person with himself, his identity, as consolidated by Erikson's epigenetic phases, might well be illumined by future studies incorporating an ethological approach, particularly in revealing the factors contributing to the development of the need for whole person relationships from the point of view of rearing the family. The survival unit of the human being is the family. The interplay of the manner in which the dependent status of the child contributes to the building up of the need for whole person relationships and the extent to which these are re-inforced by future needs stemming from the reproductive constellation within the family and of the position of the latter within the social group, provides endless scope for further work.

(5) The capacity of the central ego to tolerate conflicting needs and to organize them appears to be largely an acquired property. Certain kinds of early experience make or mar this capacity in a profound way. What starts off the ego as an adequate independent organizer, i.e. what lays the foundations for an organizing ego, independent of the mother who has been the first organizer, is particularly important.

Fairbairn's inferences about what seems to have gone wrong in his schizoid patients is in line with the work of many psychoanalysts.

The importance for the future functional power of the central ego of critical phases in the early mother–child relationship is now very familiar in phrases which have become bywords in analytic writings, e.g. Balint's primary love, Erikson's basic trust, Winnicott's true self, etc.

(6) In the relationships fashioned predominantly by the central ego the identity and reality of the other is fully accepted, i.e. the overall acceptance of the person raises the threshold of toleration for unfulfilled expectancies so that the relationship is maintained. If the frustrations in the relationship are too great despite mutual adaptation attempts, it can be ended without destructive behaviour. The concern for the other in adult relationships stems from many sources, one being the patterning of the central ego's actions by the tendency, even though this be very much a latent process, to make the real relationships approximate to that of the ideal ego with its ideal object.

Repressed needs and primitive control systems

(7) These systems comprise:

(*a*) certain need systems which may be designated *repressed aspects of object relations*, and

(*b*) *primitive control systems* (the super-ego) derived from early inhibition of certain need systems.

In contrast with those of the central ego, the relationships sought by the repressed need systems are relatively closed, i.e. the objects sought are not individuals with mature independence but are realizations of the inner figures. In extreme cases, it can be clearly perceived that the individual has a relation with an inner object with whom he is virtually completely identified, i.e. who is a part of himself. This is particularly striking in the self-gratifying perversions, e.g. the transvestist who has the sexually exciting relation with the woman with a penis by finding her in his mirror image when he is dressed up. More often the inner object acts as a scanning apparatus which

seeks a potential object in the outer world. The subego of this system then coerces these people into the role of the inner object. Such objects are not permitted to have any real independence or individuality; they have to fit the inner imago. Sado-masochistic perversions illustrate this activity, and the ease with which the individual can change roles in these perversions indicates the switch from the identification with one end of the system to the other.

(8) The goals sought by these subsystems represent *aspects of the total relationship* with the significant figures of infancy and childhood and range from relationships characteristic of early infantile dependent states of development (e.g. 'oral' needs) to genital behaviour.

(9) These subsystems have been split off because their aims were incompatible with the preservation of the ego-syntonic relationship with the needed person. The conflict gives rise to 'pain' (fear, anxiety, guilt, depression, etc.) associated with their activity.

(10) They are excluded from the conscious self by forces of varying resistance. Their dissociation from consciousness means that little or no adaptation or learning occurs within them.

(11) The original frustration apparently leads to many of them containing, in addition to the affect associated with their own aims, e.g. genital gratification, intense anger and destructiveness towards the person sought; in other words they are largely sadistic in character.

(12) They are constantly seeking outlet in ordinary relationships and/or in phantasy and thought, i.e. they have the compulsion to repeat.

(13) Their activity is particularly evocative of the super-ego systems, i.e. they are accompanied by varying degrees of anxiety and guilt.

(14) The resistance some of them show to being brought back into consciousness becomes increased:

(*a*) By their finding hidden satisfactions within the self (in which case a part of the self is treated as the object to be loved and/or hated in the forbidden way. For Fairbairn, it

is the secret tie to the repressed exciting object which is the explanation of much of the resistance to giving it up. Or

(b) when their objects are projected into other people—especially in close relationships.

(15) A particularly important feature of these needs is that, though there is a defensive tendency for the person to take them to other people than those he wishes to maintain his close good relationship with, nevertheless, there is an even more powerful trend for them to come back into any close relationship with one person. That is to say, *the repressed not only returns, but it tends to return to the representative of the more comprehensive relationship from which it was originally split off.*

(16) All of the psychic systems are inter-related functionally and their relative strengths and capacities for securing satisfaction must be conceived as stemming from a continuous process of inter-related development. The boundaries between the systems vary greatly in their 'permeability'.

These statements, based on Fairbairn's model, describe the functioning of the person in his social relationships and they provide at least the outline of a model for human inter-action, particularly for conflict in social behaviour. They are intended primarily to meet Colby's first requirement, i.e. that vari-ables should be at the right level, and his other requirements can be readily fulfilled also.

The study of the central ego, its functions and development, provide ample scope for ego psychology. The inter-relatedness of ego function and the intrusive effects of uncon-scious object-relationship needs suggest that a comprehensive statement of object-relations theory will provide a suitable framework for the development of psychoanalytic theory.*

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* I am dubious, however, about the extension of psychoanalysis to be a general psychology. Psychology requires many methods of study of which the psychoanalytic method is one. Psycho-logy is hollow without psychoanalysis, but it has to draw on many methods and data other than those of psychoanalysis.

SOME USES OF THE MODEL

A. *The aims of psychoanalysis*

The *general aims* of psychoanalysis can be stated in terms of an object-relations model as initiating and maintaining a process whereby repressed relationship-systems are brought back within the organizing system of the ego so that they can be subjected to learning and adaptation. The psychoanalyst secures this process by:

(1) Providing a specially designed situation in which there can be freer communication between the parts of the self and between the repressed systems and a special external object, himself. He facilitates these changes by inter-preting the hidden aims of the dissociated relationships as these emerge in the spon-taneous behavioural and verbal expressions of the individual towards him.

(2) The personal relationship he offers enables the dissociated systems, eventually trying to use him as their object, to be brought into awareness with sufficient affect as well as to be tested against the continuing reality of his interest. This bringing of the dissociated need systems into the requisite kind of aware-ness allows 'extinction' of some needs and learning of new objects for others to take place again.

A greater degree of integration is sought through a twofold process, viz.:

(a) Increasing the integrative capacity of the central ego system through the overall relationship with the analyst by establish-ing a capacity to transact with people more freely.

(b) Bringing back the dissociated systems for new solutions.

A certain intensity of treatment and its special setting are required for this process to be adequately maintained and regulated.

I shall not do other here than to refer to the 'setting' of the patient's total life situation as creating obstacles to the analytic relationship. Certain alterations of this may be required for the analyst's aims to be possible. For instance, parents may maintain with a child or one

marital partner may exert on the other a pressure to keep a subrelationship in being, thereby requiring the relationship to be altered for the analysis to proceed.

B. *Transference and the psychoanalytic relationship*

Transference phenomena enter into all human relationships so that their existence within the psychoanalytic relationship is in no way characteristic. All kinds of people are made the pegs on which the objects of repressed relationships are hung. What is it that is specific to the transference in the analytic relationship? I believe the answer to this question is that the analytic process permits a unique setting for the re-integration of the split relationships in the self. The affects and aims of repressed relationships tend to be acted out by all human beings in some of their personal relationships without the discharge of these affects having other than a minimal or negligible effect on their compulsion to repeat. But the analyst, starting as a good object, usually an ideal one, creates the essential feature of the analytic process in that the split relationships are re-experienced with this *one person* who does not reject them intolerantly. This is, of course, no new statement. It is universally agreed that it is the transference experiences within the analytic setting that lead to change. Karl Menninger's model of the analytic contract describes this process. I believe, nevertheless, that its implications for our structural concepts have not been fully realized. Can we account for this *crucial aspect of the transference relationship* unless it is postulated that what is repressed, as Fairbairn has described them, are bad aspects of an original unitary relationship of one ego with another whole person, the mother? In other words, can we explain why the analytic relationship is sought and maintained by the patient unless there is an original supra-ordinate structure which is trying to re-unite within itself parts that originally belonged to it, and whose segregation is sustained only by constant strain within it?

Rapaport asks if the analytic method does justice to the phenomena of human relationships or whether instead it creates artifacts. It would appear that this inner compulsive striving to unite the original splits in the ego and its object within one relationship is not a product of the analytic process but a general tendency of human personality. The literature of the world points to Fairbairn's conception of the splitting within an original unitary structure as a universal truth; in short, it is the human tragedy that 'each man kills the thing he loves'—or, at least, tries it the uttermost. But what Wilde did not know, and what object-relation theory emphasizes, is that the killing is not to destroy but is to make an infantile protest from which the good relationship will re-emerge magically.

A source of evidence with which I have had a good deal of experience in recent years and which is very telling in this connexion, is that which stems from work with marital conflicts. The commonest presenting pattern of these is as follows. In the early phases there is an idealized relationship, or at least what is felt to be a good relationship. This phase may last over years and often includes sexual relationships that are satisfying to both partners. There then begins an insidious process, frequently starting with more initiative from one partner, but sooner or later colluded in by both, through which the repressed relationships with the original significant parent figures are brought in. The particular pattern follows, of course, the specific content of the individual's history and it is remarkable at times how closely the settings and *patterns of original relationships* are reproduced. With these cases, there are many complications, but the common characteristic keeps reappearing; namely, of the bringing into the good relationship the repressed bad aspects of the relationships with the parents. In marriage, processes of this kind are universal but they are ordinarily contained by the balance in favour of the good relationship and its enrichment. Where the difficulties become of such an intensity that help is sought, then a further

feature emerges. Despite the tensions and often fairly prolonged periods of hostility and mutual recrimination, there remains a strong desire to get the relationship right. Often this is re-inforced by external considerations, e.g. for children, but this need is usually present without these factors. In view of the frustrations and sufferings of so many of these spouses before marriage, it would be expected that desperate measures would be put into action to preserve in the relationship the goodness of the early phases. What then determines the entry into the good relationship of the repressed bad relationships? The most plausible theory to my mind is that the spouses are trying to undo the experiences of an early relationship in which the bad aspects belonged with the good. Unfortunately when, as so frequently happens, both partners collude in a process of this kind the relationship becomes one in which both are living with their bad objects projected into the other and they remain stuck in this position. Psychotherapy directed towards these collusive forces in the relationship often produces good effects in persons who separately would be regarded as much more difficult prospects for individual psychotherapy.

C. *The psychoanalytic method*

Under the stimulus of the object-relations concepts as these are expressed in the writings of Bion (1961), Rickman (1957) and Fairbairn, Ezriel (1951) put forward a statement of major importance concerning the study of the psychoanalytic method. Ezriel concluded that most doubts about psychoanalytic theories centre on the validity of the psychoanalytic method. Using tripartite object relation structures as described by Fairbairn, he assumed that the psychoanalytic situation would be dominated at any one time by three forces corresponding to the three systems. Thus, the central ego would seek one relationship with the therapist, the repressed needs would drive the individual to express another, and the inhibiting subego would create a feeling of impending threat, disapproval or catastrophe.

He proposed to conduct therapy without making any historical reconstructions and to confine his comments to how he saw these three relationships determining the behaviour of the patient. In other words, the psychoanalytic session could be treated as an experimental situation provided the therapist stuck to the here-and-now forces operating in the setting.

Not only was this a way of investigating the psychoanalytic method, but in Ezriel's view it provided the much needed theoretical framework on which all interpretations should be based. The verbalizations made by most analysts during sessions can be very different in status and complexity, ranging from simple affirmations, requests to give more material, etc. His thesis, however, was that the interpretation, i.e. the crucial aspect of the analyst's verbalizations, must consist of bringing to the patient's notice the three types of relationship in the situation. (Fairbairn (1952b) also wrote a short paper subsequent to Ezriel in which he expressed very similar ideas.) That is to say, the analyst must account for what the patient is expressing to him by a response in which three components are discernible, viz.: (1) When you say (or communicate by behaviour) 'x', you are striving to maintain relationship 'a' with me; (2) but 'x' also indicates that you want to express another relationship 'b' with me, which you must not admit to *because* you fear (3) relationship 'c' in which I shall do something disastrous to you (reject, punish, attack, be sexual with, etc.). Thus the unconsciously sought relationship, the defence against it, and the reason for the defence are incorporated in these three parts.

D. *Social relations and group psychotherapy*

Freud's original study on group psychology was a remarkable contribution to our understanding of group processes. Here was one of the early examples of theory in object-relations terms because the group members became related through their common introjection of the leader as their ideal object. Kleinian

theory with its multiplicity of internal objects suggested that the social relations created by the individual would reflect situations comparable to those between the ego and his inner objects. Bion (1961), Jaques (1955), Menzies (1960) and others developed these ideas. In a number of contributions they showed how illuminating these primitive object relations of the inner world could be both in understanding and handling intra-group tensions and those between groups.

SUMMARY

I have outlined some features of the object-relations theory of the personality which started in the work of Klein and the advantages of which have been formulated so penetratingly by Fairbairn. Its main aim is to formulate a theory closely related to the phenomena of human conflict and of personal relationships. There is a danger to psycho-analytic theory and practice in trying to reduce the phenomena to components which have the appearance of being more scientific because they avoid errors of anthropomorphism. An object-relations model can be flexible and comprehensive with regard to the understanding of behaviour at any one time in terms of the here-and-now manifestations and of how these are the product of historical layerings. It has the added advantage of giving a more rigorous basis for the study of the psychoanalytic method.

Fairbairn's formulations try to do justice to the phenomena of human interaction and I have suggested that the way the personality seeks to undo its splits within one relationship is only explicable by a theory of the kind Fairbairn has stated, viz. that these splits occurred within an originally unitary structure which mediated the relationship between the infant and his first object, the mother.

Discussion of J. D. Sutherland's paper

'Object Relations Theory and the Conceptual Model of Psychoanalysis'.

OTTO F. KERNBERG, M.D.*

Doctor Sutherland has outlined a conceptual model of psychoanalytic theory derived from the English school of psychoanalysis. He has said in comparing that conceptual model with the formulations in psychoanalytic theory derived from developments in ego psychology, that 'Some of the apparent differences do not represent incompatible lines of work but, on the contrary, can be seen in substantial measure as complementary'. I believe Doctor Sutherland's precise synthesis of the object-relations theory of Fairbairn, and his elaboration of Fairbairn's model, are an important step in the direction of clarifying the relationship between ego psychology and the object-relations theory.

Melanie Klein's contributions to a conceptual model of object-relations theory (as contrasted to her contributions to clinical psychoanalysis) have been open to criticism, mainly perhaps, because of her lack of definition of the relationship between the ego as a whole and the inner objects of the ego. For example, it is not clear to what extent in her theory the inner objects of the ego are forerunners of the super-ego, to what extent object relationships are simultaneously being built up into super-ego and ego, or what the relationship is between inner objects of the ego and characterological structure. In connexion with her clinical work, Melanie Klein's school has also been criticized for what appears to many as a rather arbitrary utilization of concepts related to very early stages of the ego, in interpretations given during the first few sessions to most patients. This practice gives the impression that her group does not take sufficiently into consideration the later defen-

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sive processes of the ego, or the more advanced structure of it.

Doctor Sutherland's elaboration and re-formulation of Fairbairn's model overcomes to a great extent this criticism of the object-relations school. He has described the concept of dynamic psychic structures or systems within the ego, which are units differing to the degree they are in open transaction with the social environment, and which contain an *object relationship* (as well as a part of the ego, and the impulse derivative connected with this relationship). He has also introduced an element of historicity, of longitudinal develop-ment, which I feel is lacking as far as advanced ego functions are concerned in Klein's theory, and has also provided a link to ego psychology as represented by Erikson's concept of ego identity.

Doctor Sutherland states that only Erikson has attempted to encompass the whole ques-tion of the maturational basis of development. The work of ethologists, Sutherland believes, might provide a more flexible and illuminating approach to instinctive behaviour particularly in regard to the roots of social behaviour and of object relations than that implied in Fair-bairn's subestimation of instincts. I agree with Sutherland. Also, in contrast to Fairbairn's subestimation of instincts, I believe that Melanie Klein's contribution to instinct theory, her impressive analysis of the import-ance of aggressive and self-aggressive archaic impulses, is a fundamental pillar of the object-relations theory.

I would like to link the observation of Doctor Sutherland on Erikson to one area of possible relationship between the object-relations theory and ego psychology, namely, that of the defensive and adaptive mechanisms of the ego connected with the object systems along the developmental path of the ego.

Erikson describes the precipitation of ego identities out of identifications which centre around crises of development of the individual. Thus, there are different identities in the ego, on different levels of development, with the possibility of fusion and structuralizations of identities, as well as of conflicts between ego identities of different stages. These identities are built up of identifications which, especially as far as very early identifications are con-cerned, in turn develop out of introjections. It is my understanding that Erikson sees intro-jections as representing early adaptive and cognitive mechanisms of the ego as well as defensive operations, of a 'diffuse' type as opposed to the more delimited processes involved in identification. Identifications, as contrasted with the perceptually poor and affect-laden introjections, are closely connected with autonomous cognitive processes of the ego on one hand, with social aspects of the parental figures on the other. Identification involves the identification with roles, that is with habitual social functions accompanying the interpersonal relationship with the object at the time at which those identifications occur. We could say then, that the growth of the ego is marked by the building of object relationships that finally constitute ego iden-ti-ties which contain adaptive and defensive mechanisms connected with these object relationships. These mechanisms vary along the developmental path, so that very early object relationships introduced into the ego imply primitive mechanisms of adaptation (introjection), and later ones, more advanced mechanisms of adaptation (identification), all of which serve defensive processes.

Melanie Klein and her co-workers have described the importance of primitive defence mechanisms at very regressed levels of ego functioning connected with early object relationships. I refer especially to Rosenfeld's studies of the mechanism of projective identifi-cation and Paula Heimann's investigation into defensive mechanisms in paranoid conditions. Projective identification in Rosenfeld's con-ception implies projection of an impulse, lack of differentiation between the ego and the external object, and the need to control the external object. One might say that this is, for the school of object-relations theory, an essen-tial mechanism 'precipitating' into very early object systems of the ego. Of course, when

very threatening impulses (especially those of an archaic aggressive nature) are involved, the early object relationship which is to become an inner object or object system of the ego is such that this system is easily rejected by the central ego system and thus, as Doctor Sutherland pointed out, kept out of the influence of later integrative ego mechanisms.

In contrast, at a somewhat later stage of development, when autonomous ego functions of a cognitive nature (especially perception) are more developed, projective identification may turn into projection. By now the ego becomes more aware of the limits between itself and the external objects and thus the projected impulse is disconnected from the ego, and the need to control the object diminishes. Also, the development of memory functions may contribute to mitigate the threatening aspect of the object. Different images of that object throughout time can co-exist, thus reducing the fantastic nature of the fear of the object, and again the need to control it implied in projective identification. One might formulate this by saying that memory development helps to overcome splitting. What I am trying to say is that while primary autonomous, especially cognitive, functions of the ego develop, defensive mechanisms connected with introjection of object relations change, and therefore, also the nature of the inner objects of the ego. On the other hand, as inner objects of the ego are built up under the influence of less primitive mechanisms, and identification in the sense of which Erikson uses the term are quantitively replacing introjections (and other related early mechanisms) as the main mechanisms of adaptation and defence, primitive anxieties connected with rejected early object relationship diminish. The ego has now available more freedom for adaptive purposes; this, in turn, re-inforces the cognitive aspects of the later identifications and ego identities, which are easily taken over into the central ego. Thus the adaptive (especially cognitive) and defensive mechanisms of the ego might be visualized as a kind of 'interstitial tissue' which structures

the more definite ego identity and the advanced preconscious and conscious functions of the ego.

Trying to reformulate the above in a tentative spatial model, inner objects of the ego might be visualized as precipitates of the ego around which cognitive functions and the adaptive aspect of defensive functions construct a secondary, stable 'interstitial web'. This 'interstitial web' gives strength to the whole structure and preserves the delimitation of early object relationships. On a higher level of organization, these 'interstitial' structures actually give the 'definite form' to the ego as an organization, to the extent that even when temporary reactivation of early object relationships occur, for instance, in the countertransference reactions of the analyst, the higher structures do not break down, but keep the 'form' of the central ego and its advanced identity. Thus the refined interaction with reality is maintained, while at the same time the inner experience can be that of the more diffuse nature of an early object relationship.

In conclusion, I do feel that a possible relationship between object-relations theory and ego psychology exists, and that an analysis of the maturational scale of defensive operations, of the characteristics of early precipitates of object relationships as contrasted with those of later precipitates of such relationships, might be constructed. In such a longitudinal model, the characteristics of early defensive operations and early emotional positions connected with primitive object relationships will have an essential place. I believe that Melanie Klein herself moved into this direction when implicitly describing introjection and projection as early mechanisms of development of the ego as well as of defences against archaic anxiety.

A few final remarks on the implication for the theory of the super-ego and the theory of the id of this tentative, 'combined' model. In Doctor Sutherland's formulation, synthesizing and modifying Fairbairn's concept, an advanced form of super-ego structure corresponds to the central ego, while a more

primitive, sadistic super-ego is structurally involved in the early ego systems. This involves, I feel, a parallel conception of the super-ego as being also built up of different levels of object relationships. The sadistic primitive super-ego thus represents a precipitant of very early super-ego functions connected with early inner object systems. Such a point of view would be compatible also with Paula Heimann's statement that introjections occur simultaneously into the ego and into the super-ego. Finally, Doctor Sutherland's consideration of the question of the relative organization or lack of organization of the id is very important. The point of view that the id is being 'structured into' the archaic object relationships which constitute the inner objects of the ego appears to me an interesting and challenging viewpoint. This conception of the id may appear less surprising if one accepted Kubie's critique of the concept of psychic energy, which implies that energy is distributed diffusely through the psychic apparatus; what determines different levels of energy potential are structural elements within that apparatus and not an external source of energy to it.

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Object relations theory and marital studies

By HENRY V. DICKS*

INTRODUCTORY

In this paper I wish to express my indebtedness to the ideas of Dr Fairbairn from a corner of the psychotherapeutic field which began to make sense only after I had assimilated Melanie Klein's and his hypotheses concerning human relations and used them to construct my conceptual framework. In the Marital Unit which I run, this framework has been increasingly applied to the elucidation of interaction between two persons. It might be fairer to Dr Fairbairn if I call it 'the impact of his theory on another mind'. Let me try to describe the way in which this theory came to be used in trying to understand the tensions between married (and more rarely engaged) couples as part of the developing family services at the Tavistock Clinic.

I came to marital studies from work in the area of culture and personality connected with national character, Dicks (1950, 1952). The earliest marital conflict cases I was asked to see by a local F.W.A. branch coping with many mixed marriages continued my initial 'anthropological' bias. I met, for example, a left-wing Scottish miner's son with *his* style of life and marital role expectancies who had brought home from military service a Greek-orthodox Cypriot peasant's daughter, with *her* strict traditional role expectancies of how married people should perform their interactive functions, and her notions of right and wrong. Culture clash could account for their inability to communicate and dovetail at the level of tacit assumptions; no need to postulate personal neurotic traits in either partner. But similar disappointed role expectations were also disturbing marriages, studied later, which

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came from the same cultural and class background—even Bethnal Green! So it was *family* culture in the partners' background which had structured these tacit role expectations for self and partner. One concluded that people who came to one's clinical notice for their marriage troubles had strongly 'built-in' role models for their own and the spouse's behaviour which they were unconsciously reality-testing in the marriage and found wanting in intimate daily interaction.

Systematic history-taking and disclosures by the patients during therapy soon made us propose the hypothesis that the 'built-in' role models were based on ambivalent relations to earlier love-objects, most often the person's parents—not necessarily of the opposite sex. To this we soon added a supplementary generalization that likeness could be replaced by superficial contrast to the past love-object, as if counter-cathexis had been at work. This was, for example, quite naïvely stated by one man who said he married his wife because she did not resemble his possessive mother like all his previous girl-friends had done. A third concept forced upon us by the data was that of being best able to understand the marital behaviour of *some* of our patients when we interpreted it as persecution in the partner of traits, weaknesses or faults rejected by the self; or again loving or seeking (often in vain fantasy) in the partner those parts of the self which were missing (Dicks, 1953).

The common factor in these three situations was the perception of the marriage partner at emotional level *as if* the partner was not himself but some other person or *part* of a person. This often coincided with dovetailing behaviour by the subject in his or her own role taking—*as if* in relation to the spouse one had to be one's own parent, or could only be a little

boy or girl, and not one's ordinary adult self such as with friends or at work. In other words in marital tension states there was a great deal of mutual attribution or projection going on, with each spouse perceived to a degree as an internal object. In a short time a young wife could receive the cathexis of, say, a persecuting mother, and at the same time be felt as a part of the subject's own severe super-ego, to use pre-Fairbairnian terminology. The situation which was in some cases intense enough to be called 'folie à deux', was all the more remarkable in that we were, by selection, dealing not with generally sick or ineffective personalities, but with a sample of people well above the median in intelligence, worldly success and upward social mobility. Some were regarded by friends and neighbours as 'ideal' couples. Only in the intimate symbiosis was there an underground working-out of old object-relations. Such a split within the relation is described, for example, as follows: 'The moment friends come we are united. When the door shuts on them, she starts on me.' Clearly, there is a top level at which a couple have a common purpose, a need to be seen as a harmonious unit; and a deeper level at which they are carrying on some old feud, using each other as the 'projection-object'.

SOME FEATURES OF MODERN MARRIAGE

Modern English marriage is rarely 'arranged', or dependent on permission of actual parents. More often it is an autonomous agreement between the partners, at times in defiance of parental wishes. This contrast with traditional marriage custom also means that it is no longer buttressed by accepted moral certainties which in the past provided a support if not a strait-jacket. Both geographically and sociologically, the married pair form a new unit, often in the midst of strangers. The partners expect to be 'all in all' to one another. This need to create a new integrate greatly adds to the 'load' the relationship has to bear—many 'sub-identities' and facets of personal needs require to be

satisfied by each other and by the few children in our small urban families which are the present norm.

The capacity for, and the interpretation given to meeting these demands and role expectations will in large measure be the outcome of a learning process we call personality development at the level of the primary object-relations in a family of origin which has often been itself a similarly 'overcharged' in-group. In our appraisal of this process Fairbairn's *schema* proves to be more enlightening than the classical doctrine of 'stages of libidinal organization'. Starting with H. S. Sullivan's definition 'Psychiatry is the operational statement of interpersonal relations', it was unhelpful, well-nigh meaningless, to analyse the content of a complex interaction between two adults in the atomistic, quasi-neurophysiological terms of impulse gratification implicit in Freud's original system. We have seen many couples whose fully established genital sexuality was later impoverished or even extinguished by tension and conflict, over religious and political value systems, or by some other rejection of one *person* by the other. Genital potency was not impaired with a new and congenial lover or mistress. This attracted one to Fairbairn's internal-object-relation psychology because it is a statement more nearly covering the behaviour of 'whole persons', albeit these may suffer from internal splits and conflicts. Fairbairn has moved the ego to the central position, instead of regarding it just as a mediating 'organ' between an inner world and outer environment. It is persons who interact, and when their interaction becomes disturbed their impulses—e.g. the sexual one—follow suit.

If I understand Fairbairn's position correctly, ego development is furthered by the secure passage through a succession of positions of ambivalence towards objects. It begins with the crude and undifferentiated 'good' and 'bad' relations, first proposed by Melanie Klein, and grows towards an integration of ambivalence which can be tolerated both in self and in others without splitting the

antithetical components one from the other. In a healthy outcome of this conflictful process, relations with objects will be felt to contain the promise of love and security, of satisfaction. As the result of a preponderance of 'good' results of reality-testing with primary figures (self–mother, self–father, self–siblings, father–mother, parents–siblings, etc.), there emerges not only a unified central ego to whom libidinal and self-assertive powers remain available for growth, but also a stored reservoir of 'relational potential' with these figures which are a person's good internal objects. Through internalizing them he learns to love as an adult, because he has felt, and identified with, adult love cherishing and accepting him and others. Likewise he or she will have experienced the tolerance and mastery of anger in a non-destructive or loving way. This potential is at the service of object-relations especially in marriage and parenthood, probably starting with choice of mate.

In a less fortunate case—the kind of case we see as marital patients—there will remain persistent need-demands towards the primary figures because they were experienced as so frustrating and hate-arousing that splitting of the relation-potential with them occurred in ways which Fairbairn and Guntrip have postulated. Consequently this hate is felt to be both inside the self *towards* the object, and towards the self *in* the object from outside. The ego's own identity is preserved by defensive splitting-off of parts of itself much as a lizard will shed his tail to an enemy. These split-off parts lie dormant as 'sub-identities' until they are reactivated by a new situation of intimacy. Modern marriage is perhaps the greatest challenge to ego-strength or maturity. The central ego, even if impoverished by the loss of much of its early libidinal capacity held down by anti-libidinal persecuting ego, can get by in 'non-libidinal' activities. Hence perhaps the incommensurateness between worldly success and competence in close sexual and emotional relationships. Not enough that modern parents and education have prepared the children for social and economic independence

—hard though it is. Perhaps it is just this one-sided development which damages the tender shoots of emotional growth. For marital success the crucial problem is how to preserve and make available to the personality the tolerance of the needy, dependent, libidinal child—to allow room for regression.

Marriage is a relationship *sui generis*. It is at its broadest a contract by two persons ('with their central egos') to play certain social roles in ways which not only satisfy the needs of the other *as far as they can perceive*, but also to varying degrees fulfil the requirements of the culture, the mores of the society of which they form part. More fatefully, however, it is also a *transaction* at a deeper level between their hidden sub-identities derived from the above sketched developments. In clinical fact, after a varying time-interval, the adult socio-biological purposes of the two spouses' central egos may become sabotaged by the inexorable pressure of the hidden parts of their personalities. These I now feel most comfortable in ascribing to the dynamisms Fairbairn (1952) has termed the libidinal ego and the anti-libidinal ego, to which I have also added Guntrip's (1961) recent subdivision of the regressed 'oral' ego.

EGO SPLITS AND MARITAL TENSIONS

It is characteristic of marriages we see clinically with one or another of the syndromes of marital disharmony that one or both partners fail to confirm the other's real personality or identity. Instead they require the other to conform to an inner role model and punish them if the expectation is disappointed. Much marital conflict can be shown to stem from strivings to coerce or mould the partner by very rigid and stereotyped tactics to these inner models. Such Pygmalion techniques naturally arouse resistance and frustration of the other's ego needs, even though at deeper level they are part of a *collusive process*. It was, in fact, the discovery of this collusive relationship at unconscious level (which following Spiegel (1957) we included under the broader term of

'transactions') that made us turn decisively to Fairbairn's concepts. Only the assumption of ego splits makes sense of the paradox that 'cat and dog' marriages endure, despite recurrent or even constant mutual provocation of each other to apparently destructive or belittling and persecutory role behaviour. This mutual need of each other precisely as the outwardly bad object is such a strong bond that it can defy all therapeutic effort. To this destructive symbiosis the central egos' contribution of rationalizations, such as loyalty, wish not to endanger the security of the children (who may be profoundly disturbed by living in such a home!) or fiscal and material considerations, may be quite modest.

I visualize the obscure process of mate selection (i.e. the person one decides to *marry* and not merely have a flirtation or affair with) as largely based on unconscious signals or cues by which the partners recognize in a more-or-less central ego-syntonic person the other's 'fitness' for joint working-through or repeating of still unresolved splits or conflicts inside each other's personalities, while at the same time, paradoxically, also sensing a guarantee that with that person they will not be worked-through. Thus they both hope for integration of the lost parts by finding them in the other, and also hope that by collusive 'joint resistance' or mutual defence this painful growth can be by-passed. It is these rigid defences which tend increasingly to invade the stage to the distress and impoverishment of the partners' sense of identity and ego strength.

Consider the paradigmatic case of an insecure 'man's man' who is greatly drawn to and marries a 'little woman', whose feminine emotionality he proceeds to belittle and persecute. We can often succeed in ascribing such intolerance to rigid defences in the man against his own libidinal ('little boy') ego, by identification with the anti-libidinal internal object which rejects dependence as 'sissy' feeling. He married because he loved the promise of re-uniting himself with the lost potentiality he sensed in his wife, but he is compelled by his inner split to deny and persecute his libidinal

ego in projective identification in his marriage. The complementary-need system in such a man's wife which is being satisfied (if she sticks to him) is a central ego which keeps its identity and security by submitting masochistically to a tyrannical or belittling parent-figure; this is better than no relationship at all. The 'promise' of the marriage for her was the safe continuation of this original sado-masochistic relation to the anti-libidinal ego—which, as we now see, is *shared* by the partners. One acts the role of the sneering, belittling anti-libidinal ego; the other reacts as if he were such and cannot use any other qualities to combat this dreaded/loved figure.

An even commoner paradigm in our case material is the obverse of the above—the woman who because of her need for fusing her splits between anti-libidinal and libidinal inner objects idealizes a man as promising to be the Prince Charming who will awaken her rejected feminine libidinal self which she also has to reject. But such a Valkyrie or Sleeping Beauty picks on a dependent, gentle man with many feminine traits who in the course of the marriage is progressively castrated and subjugated. Here again, the collusive mate choice and conduct of the relationship is one in which one partner comes to represent the anti-libidinal, tyrannical ego (most often based on a forbidding mother), the other the 'poor little' tender, loving libidinal ego, often to the point where sensible co-operation between the impoverished central egos of the partners almost vanishes.

Teleologically, such marriages continue because of the real need for growth and integration. The marriage—the dyad—here represents a total personality with each partner playing the role of 'one-half' of the unrecognized conflicting polarization, instead of a complementary growth towards individual completeness and enhancement such as is possible in the healthy marriage by acceptance of the ambivalence of a 'mixed' person. It is still a sharing, sometimes to the point of reversal of ordinarily understood male and female roles. At the same time there is a split

within such a marriage—the correct, even 'happy' social façade the dyad conspires to present to the world (their central joint ego), and the conflict inside the privacy of the marital interaction and nowhere else. It is the best integration the couple are able to achieve, granted their antecedent traumatic experiences.

Marriage is the nearest adult equivalent to the original parent–child relationship. Thus its success must revolve round the freedom to regress. The freedom to bring into the adult relation the deepest elements of infantile object-relations is a condition of growth. To be able to regress to mutual child-like dependence, in flexible role exchanges, without censure or loss of dignity, in the security of knowing that the partner accepts because he or she can projectively identify with, or

tolerate as a good parent this 'little needy ego' when it peeps out—this is the promise people seek when they search for the one person who will be unconditionally loving, permissive and strong—who will enable one to fuse all part-object relations into a meaningful whole and be enhanced by it. The search for this in heterosexuality determines the persistence with which people seek their 'ideal mate'. They may divorce only to re-enact the pattern again. Or they may desperately cling together and repeat the old frustrating object-relations using each other as victim and aggressor.

In this very brief sketch I hope to have shown how Fairbairn's views have enabled me to make something like a coherent conceptual framework for the understanding of marital difficulties, perhaps the clearest field of study for his valuable theory.

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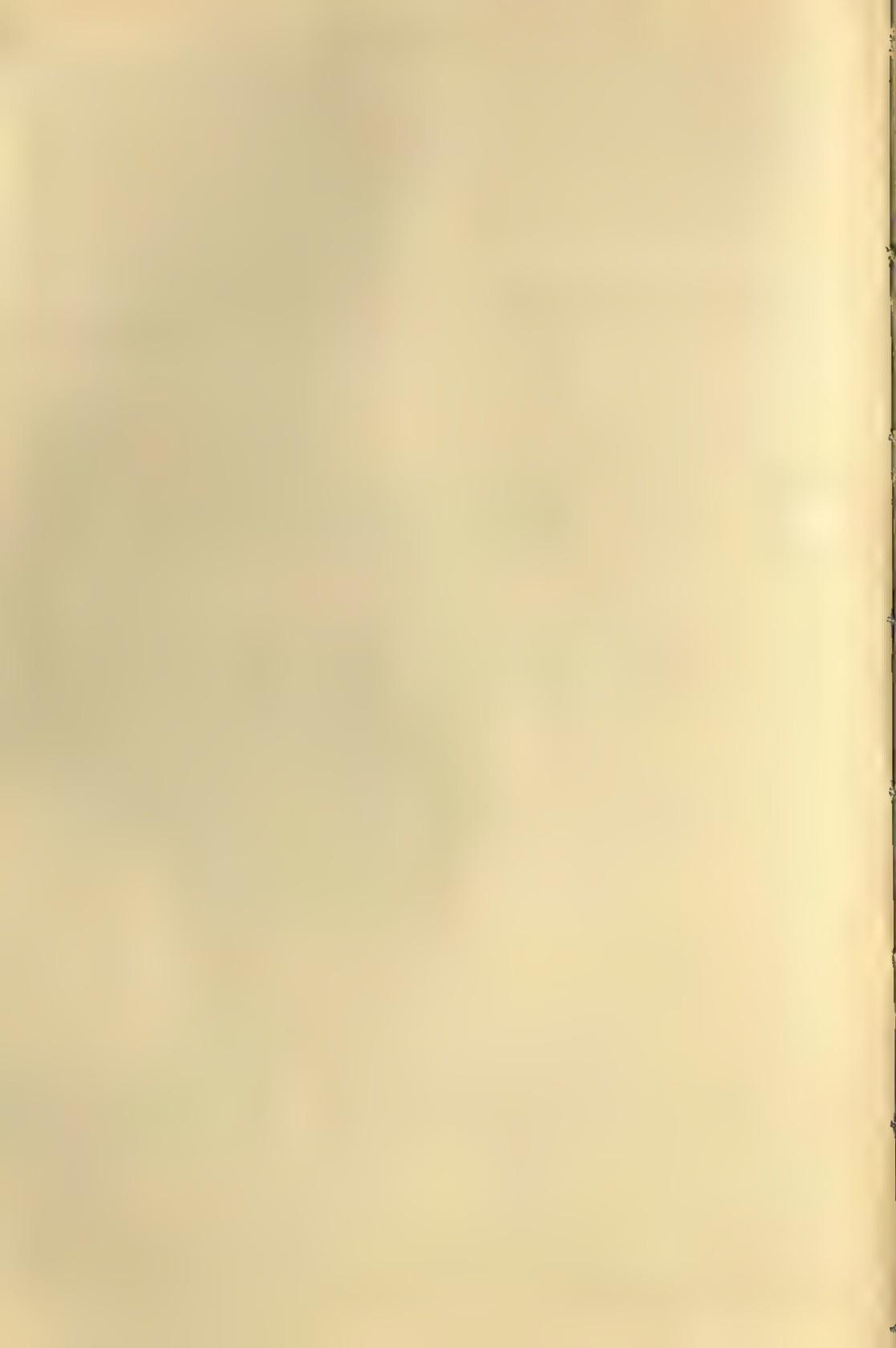
Observations on early ego development

By R. E. D. MARKILLIE*

Fairbairn has spoken of the psychological and the biological as different levels of abstraction. In this paper I have tried to demonstrate that valid as that point of view is, one result of it can be too great a separation of these levels and the likelihood that one is studied at the expense of the other. It is useful to superimpose them to see how each can illuminate the other and stimulate further growth. The advance of the biological sciences is bewilderingly rapid on the one hand, and to the non-analytically trained person on the other, statements about the human inner phantasy world so apparently esoteric, that it is important to try to keep some kind of integration between the two. To the practising psychiatrist so much of his work is empirical, and so much of his research directed towards bodily function, that it is even more important to try to establish a relationship between these two levels, if more effective research and treatment is to follow. Fairbairn (1958) himself has said 'that his chief conscious interest now lies in presenting a more adequate formulation of psychoanalytic theory' and hopes that its application will achieve a more effective therapeutic instrument.

He has introduced a valuable new emphasis by providing a new model for his psychoanalytic thinking; the result largely of the different intellectual discipline with which he approached his subject. I consider it unwise, however, to refer to his work as a complete object-relations theory of the personality, because 'complete' can so easily be taken to suggest finality or closure. I think it pertinent in this paper to try to enquire into some of his ideas, to achieve a greater fit between them and other contemporary psychoanalytic thinking, because by and large they have not received either wide acceptance or recognition.

Fairbairn's isolation from the main stream of British psychoanalysis has both enabled him to think more originally than he might otherwise have done, as well as providing the stimulus for this. However, this stimulating isolation has had its negative result too. One such will not be discussed in detail in this paper, though I consider it very much needs discussing. There seems to be a major discrepancy between Fairbairn's psychoanalytic technique and the technique discussed in some London training groups. This is no bad thing in itself, but unless there is a close awareness of what goes on in treatment it may have important but undesirable scientific consequences. The conclusions drawn from a particular treatment will be seen quite differently and therefore be evaluated differently in another. A recent example of the consequences of isolation occurred in his 'treatment' paper (1958), in which he says he has abandoned the couch technique and that this represents an attempt to put into practice the logical implications of the object-relations theory. He clearly regards the patient on the couch as being isolated, an opinion which many who have been in such a position would hardly share. The apparent discrepancy of views that emerges here is probably the result of a lack of real exchange of the nature of the respective therapies, which is in itself the most difficult communication problem that psychotherapy and psychoanalysis in particular has to face. I think there is little doubt that a difference in technique does contribute to some of the failure to understand and share his views. Guntrip, who has experienced his technique, could therefore more easily understand and propound them.

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Fairbairn emphasizes the distinction between personal and biological and between therapeutic and scientific. This leads to a second negative result of isolation which I wish to discuss at greater length. His attempt to keep psychology psychological and biology biological has resulted in too much separation, it seems to me. He believes that psychological explanations of human behaviour must necessarily be couched in terms of mental processes. Biological explanations belong to a different level of abstraction. Nothing that goes on inside a person can be impersonal. One of the questions asked in this paper is 'what does "personal" mean?' Though it is necessary to separate, in order to describe and emphasize, the fact which makes human development and behaviour so complex to unravel, is the fusion of these two aspects. This paper is specifically concerned with beginnings because it seems to me that, at that point, a study of our earliest experiences throws fresh light on this argument. It also seems to me that the very words 'person' or 'personal' need to be examined to see what precisely they mean at different phases. I find the use of the word 'personal' misleading. It can be said that the seed contains the ultimate flower. Another conception was of the homunculus in the sperm cell. In this sense some of our development is almost pre-personal, yet the person presumably has some continuous but changing representation, from potential to actual. Fairbairn speaks of the inadequacy of any attempt to interpret problems of the personality in terms of post-Darwinian biology. He abandons that part of Freud's theoretical system which aims at providing an explanation of problems of the personality in terms of instincts and erotogenic zones. I believe this abandonment to be a step in the right direction, but fortunately post-Darwinian biology—whatever that is—has not stood, nor cannot stand, still. It is true that Freud's conceptual structure was based on a scientific theory, which is now in many ways outmoded, but by the same token that which Fairbairn has used will soon be—if not already is—out of date, and the basis of what I now

write will also be superseded. Our need as far as possible is to conceptualize development in a way which will anticipate future discovery.

I hope to demonstrate that it is possible to modify still further Fairbairn's model, with the consequent need to modify some of his premises. He developed his object relation views independently of, but concurrently with, biological studies, which began to look at the nature of the mother–child tie and the links involved in the development and maintenance of social behaviour in animals. Swift developments in the possibilities of communication have led to studies on the nature of human and animal communication. Something of the importance of signals and their reception, what elicits them and what they in turn elicit, are being studied. Signals in fact provide an opportunity to comment on one of the apparent discrepancies between personal and biological. A signal has an objective impersonal basis. It may be measured in microvolts or units of light or in terms of speed, but it is at the same time a simple or maybe highly complicated message, the meaning of which can only be considered at the personal level. I believe that these studies illuminate Fairbairn's views still further.

Probably because of his previous training, he writes with great lucidity and conceptualizes particularly clearly. This may be a reason why he sometimes expresses his views with the economy of a creed. This clarity and simplicity is deceptive. It may be dangerous, because on the one hand it encourages undue reification, and on the other hand the fact that they are so simply expressed, even though new and unfamiliar, encourages their overlooking. He has expressed his outline of human psychological development and structure most succinctly in his 'hysteria' paper (1954). I wish to take two of these postulates as the stimulus for an enquiry on the nature of the events or structures that he is describing.

(1) 'The pristine personality of the child consists of a unitary dynamic ego.'

(2) 'The first defence adopted by the original ego to deal with an unsatisfying

personal relationship is mental internalization, or introjection, of the unsatisfying object.'

It is pertinent to compare these remarks with the opening verses of Genesis, which are a far from unscientific statement of beginnings. To make it humanly comprehensible, an enormous time span and an enormous complexity of events is there compressed into a few days and a few seconds' reading. It is first the complexity and the time relationships of the events that Fairbairn is describing that I wish to dilate upon. I believe the first of these statements to be true, but what does it mean and what are its implications? He speaks in the second as others have done of internal objects, but is at pains to point out that they are structures within the personality. But what is the nature of such objects? We are faced with the difficulty that here we try to express in words something which has no verbal equivalent, something which is at the fringe, if not beyond the fringe, of observation, and something which is so overlaid by subsequent development that the first impressions on the palimpsest, that is our ego, are virtually indecipherable.

The study of these first impressions is important, because I believe that in this area will lie the integration of the views of those who are convinced of the primacy of inheritance, and those who favour the importance of environment and nurture; between those who favour learning theories and the importance of conditioning, and those who favour the unlearned components of behaviour. The earliest events of our lives so affect its fabric, that there can be little to distinguish their effects from some of the truly genetic ones—they virtually become fabric, part of the ground bass. I will hazard an opinion here. Sleep disturbances are one of the commonest of all psychiatric disorders. In some patients it looks as though the disturbance of their sleep, like that in the fairy story of the princess, who could not sleep well because of the pea beneath her twenty mattresses and twenty feather-beds, points to an early disturbance which may be overlaid by an extremely sophisticated and apparently suc-

cessful subsequent personal development. The diurnal rhythm which seems to influence so many of our physiological functions may well be set in motion and maintained by such early and almost unshakeable conditioning. Just as the germ cell contains the full bodily potential, so the neonate ego contains the full personality potential. As we have been reminded recently by the Thalidomide tragedies, disturbances in early development produce severe deformities. In a similar manner, it may be that disturbances in early ego development leave personality defects, which are of lasting consequence. I wish to emphasize this point. The traumatic impact early in foetal life, if it was not severe enough to produce death of the foetus, did not stop growth as a whole but it proceeded relentlessly on, steadily magnifying the deformity from a tiny scar to, say, a grossly distorted or under-developed limb. Ego development is probably much the same. If personal trauma is not lethal, then our very viability, the fact that development must go on, can lead and does lead to the formation of personality defects.

I wish now to look at a few other models of early human behaviour to see what light they throw and how they compare with Fairbairn's views. Bertram Lewin (1951) has suggested one in his *Psychoanalysis of Elation*. He writes: 'Sleep, basically, comes from oral satisfaction. The baby after nursing falls into a presumably dreamless sleep. Theoretically, it may be more correct to speak of the baby's having a "blank dream", a vision of uniform blankness which is a persistent after image of the breast. Later in life, this blank picture of the flattened breast, preserved in dreams as a sort of back drop or projection screen, like its analogue in the cinema, comes to have projected upon it the picture that we call the visual manifest content of the dream. The fulfilment of the wish to sleep produces only sound sleep and the dream screen. So far as falling asleep reproduces the infant's first sleep after nursing, it reproduces the fusion of the ego and the breast. The primitive sleeping ego is id except for that dream screen, the erstwhile breast, sole

and first representative of the environment' (p. 83).

This point of view is in line with the contemporary thinking that ego development arises from the impingement of an external environment and its stimuli on a receptive ego. Its ability to perceive, or the possession of a working perceptual apparatus, is vital to the completeness and soundness of that development. Although Lewin could be said to perpetuate Freud's scheme of the ego developing on the surface of the id, he is talking about a unitary structure, though not perhaps a dynamic one. Like Fairbairn too, he regards the good experience, satisfaction, as leading to the blank experience. Good sleep is opposed to bad sleep, which is disturbed sleep from the intrusion of unsatisfied wishes. Because it is a hypothetical model rather than one based directly on observation, Lewin has, like many psychoanalytic writers, paid excessive attention to orality and feeding as the primary mode of human object relations. But it does assume the creation of a good internal structure, a foundation on which much else is built, the result of the first physical experience, which is at the same time an object relation. Fairbairn has stressed that development, instinctively speaking, is not haphazard or chance, but that the most important impingement is that of the mother, who is instinctively sought and who at the same time seeks. Some of Freud's early ways of expressing instinctive ideas have always struck me as suggesting an isolated organism, scanning space in an endeavour to find a source of satisfaction. This same concept of isolation must have tended to produce theories of auto-erotism or of primary narcissism on an objectless basis.

Ethology has thrown and continues to throw a great deal of light on this. To say that infants are object seeking, as Fairbairn does, is to express an idea in a particularly teleological way, though not necessarily one to be rejected. It represents a retrospective view. It presents again one of the dangers of simplicity because it is easy to think of object seeking at an almost conscious level, whereas it is certainly precon-

sciousness. Indeed consciousness of external reality comes only with the satisfaction of some at least of these early needs. The baby's component instinct of crying, as Bowlby (1958) has described it, certainly does not imply any conscious or even unconscious awareness at first of a maternal object. I suppose it could be argued that an unborn child has heard sounds, including its mother, which provides it with a stimulus. It is true that in certain birds the parent and the unhatched young do communicate by sound and so assist the hatching process. But no child is born without a mother and the very existence of crying implies, at the level of natural selection, a responding object. The cry, as a signal, elicits a mothering response from someone, usually the mother herself, who at once by so doing prints a message, codes instructions on the ego and leaves it altered by its experience irreversibly. If not by the first experience itself then very soon afterwards. The infant who emits signals which go unheard dies and the ego is extinguished before development can begin. The bond of communication by sound between mother and child directs the baby to the right quarter, though she has begun this by her handling and holding even earlier. It gives it an awareness of mood, of what to expect, the mellifluousness of gratification, the stridor of anxiety, the sharpness of rejection, which undercuts all our later verbal experiences even though speech comes to form our most precise, informative and versatile form of communication.

It is probably questionable to speak of an inborn phantasy of the breast, though it may be a useful way of thinking. It could be argued that, if the human infant is born with an already developed mechanism to suck vigorously on a suitable object inserted a requisite distance into its mouth, then there may be some kind of mental counterpart of this and even expectation of it. Susan Isaacs (1952) formulated a concept of phantasy, which has always been attractive to me and somehow convincing even though it could probably only ever be conjectural. She says: '...this "mental expression" of instinct is uncon-

scious phantasy. Phantasy is (in the first instance) the mental corollary, the psychic representative of instinct. There is no impulse, no instinctual urge or response which has not experienced an unconscious phantasy.' Our problem is that it is difficult to think of unconscious phantasy without contaminating it with conscious processes with which we are more familiar. I suggest that all proprioceptive experience has its phantasy counterpart. The infant which moves and functions as a whole, though not yet aware of its parts, has some sort of psychic integration. Threats to that integration are similarly psychically represented and perceived. I believe this argument is objectionable to Fairbairn at least as far as it suggests a structureless phantasy world. Even if it could be argued that such a world exists, or is conceivable, it can have only a theoretical existence. The very first experiences provide a structure or confirm or deny any pre-existing phantasy. By their very happening they modify the ensuing psychic representations and expectations.

Bion (1962), in trying to propound a theory of thinking, has taken this up in another way recently. He believes that thinking has to be called into existence to deal with 'thoughts'. '"Thoughts" may be classified, according to the nature of their developmental history, as preconceptions, conceptions or thoughts, and finally concepts....' Like Fairbairn, he is discussing an aspect of human development in a highly theoretical form, though he includes good experiences more than Fairbairn does. He utilizes as his model the psychoanalytic theory that the infant has an inborn disposition corresponding to an expectation of a breast. ...'The preconception (the inborn expectation of a breast, the *a priori* knowledge of a breast, the empty thought) when the infant is brought in contact with the breast itself, mates with awareness of the realization and is synchronous with the development of a conception.' Perhaps this conception is another way of expressing, or the most primitive form of, what Fairbairn is speaking of when he says that internal objects are structures. But in

what form can internal objects or structures be internalized and stored, unless it be as codes on some substrate, rather like psychic genes? Bion then mates the pre-conception with a frustration. The mating of an expectation of a breast with a realization of no breast available for satisfaction is experienced as a no-breast or 'absent' breast inside. The next step depends on the infant's capacity for frustration. If it is sufficient, the 'no-breast' inside becomes a thought, and an apparatus for 'thinking' develops. If it is inadequate, evasion or modification of the frustration is necessary. And presumably since the infant is utterly physically incapable such action can only be omnipotent in phantasy. Incapacity for toleration leads to the fact that what should be a thought, a product of the juxtaposition of pre-conception and negative realization, becomes a bad object, indistinguishable from a thing in itself, fit only for evacuation. His statement is an attempt to think out normal development in such a way that it could be used and added to without fundamental alteration. We can include other hypotheses: one, for example, might be that genetically pristine egos may well vary in their capacities or in their viability. His suggestion that thinking is developed to deal with 'thoughts' postulates pre-existing 'thoughts', pristine mental life, another way of describing what Isaacs has tried to do. It interests me particularly because it fits in with my conceptions of drive and motivation, namely, that we are, so to speak, set in motion as developing entities containing as much impetus, divine spark, libido, call it what you will, as we ever have. That is the biological aspect, but that impetus is called into action and controlled; our personalities are shaped by our object relationships.

The second of Fairbairn's postulates is even more condensed than the first. It provoked a number of questions and criticism, for the internalization of good objects, as the foundation of good ego development, had formed an important part of some psychoanalytic thinking. Fairbairn stated in the same paper that he could think of no motive for the introjection of

an object which was perfectly satisfying. In answer to criticism of his view that it was always bad objects that were internalized in the first instance, he revised it thus. The differentiation into good and bad takes place only after the original (pre-ambivalent) object has been introjected, and that the differentiation is effected through splitting of the at first neither good nor bad internal object, but in some measure unsatisfying one. This formulation is unsatisfactory as it stands. It is possible to think of it as a process of almost conscious selection, whereas it must be operative long before. Presumably he wishes to differentiate what he feels to be normal growth and development from the abnormal, though he would not deny that bad objects are inevitable in this life. Similarly, Bion seems also to make a differentiation between what can become a thought, or capable of being dealt with by thought, and what becomes a bad object requiring different action.

What happens; what motivates our first experiences? In trying to answer this I wish to draw attention to certain observations which concern respiration. Having experienced asthma early in life, a remark of Kubie's struck a chord in my mind as soon as I first read it. In his paper, 'Instincts and Homeostasis' (1948), he talks about respiration as a primary or vital instinct. In discussing the role of warning mechanisms he says this: '...it is not strictly accurate to say that we breathe because we need oxygen; but only that we breathe because if we did not breathe then we would very soon begin to need oxygen, whereupon we would have to breathe or else die. Actually in normal life we breathe for psychologic reasons before we have to breathe out of physiologic necessity. *There is a faint phobic stir underlying every breath we take,* as the breath-holding Yogis well know.' This may no longer be physiologically up to date yet it seems to be pertinent still. The italics are mine. It is obvious why the anxiety potential, of which he speaks, was perceived by me through sensitizing and threshold lowering, whereas in other circumstances it might have passed unnoticed.

Gunther (1961) has more recently produced some extremely interesting observations of the nursing couple which deserve much wider study and validation. I will neglect her remarks about the stimulus to sucking and concentrate on respiration. She describes a baby which fights its mother with its fists as the typical action of a baby when it is in anoxia. Such babies protest as soon as they are put to the breast, once they have experienced something. That experience seems to be obstruction of the airway either by the upper lip being pushed up over the nostrils or the breast covering them. She describes it crying and boxing itself off. The attendant midwife is quite likely to shove it on harder and it boxes even more. She says that this fight needs only to occur two or three times before the baby begins to cry when it is turned towards its mother. She has seen, by the fifth day, babies cry when turned on their side from the expectation that they will be put to the breast. Tragically to complete the circle most mothers find unendurable this rejection of themselves and they lose all wish to feed such babies. If this is substantially true it is a brilliant vignette of nascent neurosis and it demonstrates very well the two-way process which must occur in all human reactions. The child fears something about its mother which occurs through no fault or no conscious wish of hers and she in turn fears its apparent aggression and rejection. Though I have used the word 'fault' here, Gunther introduces another complexity by suggesting that breast shape and formation—an inherited characteristic—makes feeding easy for some and difficult for others. It should be noted that aggression here is first an agonal response to threat, a displaced or accelerated form of the infant's energy potential. Nuzzling can be part of a delightful, close, warm oneness and yet it can also be fraught with anxiety. It is pertinent to compare schizoid withdrawal with this, even though it may look superficially to be anxiety free. Here is a prototype withdrawal based on threat. I find it difficult to think of the threat mechanism in personal terms as I think Fairbairn would

choose, but as soon as it has been alerted by an object, then for the child that object, or that function of the object, is bad.

There is an interesting parallel here between this and the 'cloaca theories' that have been outlined in the past. Some sexual difficulties, in women in particular, have been attributed to the fact that excretion and reproduction share the same anatomical locus. Here is an earlier example still where feeding and breathing are so close that one can impede the other. Gunther describes this as occurring in the first days of life. It is difficult to conceptualize what this means. Using the palimpsest analogy such disturbances are so rapidly overlaid, that their significance can be missed because they are so hidden. At the same time because they form the very first experiences of all, and because anxiety and aggression have been liberated, they may continually exert their influence or repercuss when the ego is stretched. In our ordinary history taking, how likely are we to be able to obtain evidence of such early threats? A longitudinal study of the development of a group of children, difficult as it is, could conceivably be used to demonstrate whether subsequent personality effects occur or not.

This leads me to a brief consideration of the concept of drive or libido, which I think is necessary to set these things in perspective. Freud's hydraulic metaphors have been rightly criticized and it must be noted that Fairbairn still speaks of libido flowing. When power was transmitted in this way and factories were run by complex shaft and belt drives from central engines, such metaphors were not out of step. Now that Mariner II can be switched on to obtain and transmit information as it passes close by Venus, and Telstar can be 'tricked' into resuming transmission after weeks of silence, we have surely other models by which to think of our communications and the nature of our drives. The very word 'drive' suggests energy or something moving from one place to another. In the older methods energy needed a structure for its transfer, but many contemporary structures contain their own energy sources and are switched on or off, speeded up or slowed down by signals. We are more like them. Life and energy is intrinsic to every part of us. What struck me most with Bion's argument was that he postulates the existence of an intrinsic mental life waiting to be called into action. Our cohesion only persists in that life is fed and maintained with oxygen first, then water, then food. Each of us as individuals need so much fuel rather like a rocket ascending into outer space. The germ cells are carried like capsules on its back. The energy involved in our personal processes, our object relations, our drives, is of an altogether different order, barely detectable as pulses and signals in comparison with the energy of the propellant.

It would be easy to push this analogy too far but it seems to me that far too much research goes into studying the rocket motor and the propellant, and insufficient into the nature of the electronic controls and tracking networks, when it comes to trying to understand the nature of mental disorder, a point with which I think Fairbairn would agree. A beautiful example of this energy difference, this human joy and predicament, occurred in my general reading while writing this paper. I am indebted to Adrian Stokes (1955) for translating this sonnet by Michelangelo: 'My eyes have the power to encompass your beautiful face near or far: but my feet are forbidden, lady, to bring my arms and hands (the rest of my body) where my eyes can go. By means of the eyes the soul, the intellect, are able to ascend to you and embrace your loveliness; but the body, in spite of great love, lacks this privilege because it is heavy, mortal: and since I have no wings I cannot follow an angel in flight: I must satisfy myself with the power of vision alone. Alas! If you exert as much power in heaven as you do here, entreat and obtain that my body shall be changed wholly into one (great) eye, so that there won't remain any part of me which cannot enjoy you.'

If we are not fuelled there is a run down, which may be a steady, slow fall, though more likely it has a steep roll-off at the end. Using

Kubie's idea, the signals warning of this run-down flash strongly in advance of the run-down itself. To me this run-down is the basic human angst. The mental counterpart of the physical threat of decline and dissolution has to do with, or is identical with, the much disputed death instinct. This instinct can neither be a wish nor a drive to return to the inorganic state from which living matter came. It can be the way of expressing the inner representation of the inevitability of this return unless certain conditions are fulfilled which make for survival. I think Freud was right in ultimately choosing only two forms of instinct, those of life and death. Neither are wishes nor drives. There is no drive to live—one lives. But living is incomprehensible without time as a dimension. In the sense that there is a progression, a drive can be spoken of. The organism has a life of its own, which continues on in spite of trauma or deflexion. Even though at first the human infant is completely helpless, there is a sense in which its mother only does the holding, while the organism gets under way. We see in physical disease the fact that the body's repair organization can sometimes create conditions worse than the original injury, or in malignant disease necessary proliferative processes go haywire. It is probable that psychically speaking a parallel state of affairs occurs. In physical disease one of the body's ways of reacting to stress is by hypertrophy. Martin James (1960) has drawn attention to the fact that the disturbed infant may react with precocious ego development. This is an important observation, because, in our human pride in selecting bigger and better breeds or strains of animals and plants, and in contemporary competition, the precocious child is sometimes considered to be the desirable and normal one.

Bion commented on the fact that omnipotent phantasy was the only personal resource of the helpless child. This same phantasy can only become the way in which reality, which has permitted survival, is seen and interpreted. But each experience, each memory, becomes available and modifies future phantasy and indeed can become thought. To return to my analogy for a moment. The rocket has a real flight, but the controlling and tracking apparatus can simulate a flight, can behave as though one is actually taking place, can anticipate changes of course. We, too, can do this, in phantasy only before the event has ever occurred, but more realistically based afterwards. In his sonnet Michelangelo describes this simulation, as well as how potent it is and what gratification it can provide. The aesthetic exercise itself has become one of our chief pleasures.

In our beginning then there is present the pattern and the possibility of our ending. Since this is so there is always a motive for good internalization. Every satisfying experience removes or defers what would otherwise lead to danger. It is probably true to say that in health or in healthy development optimal satisfaction has prevented the imprinting or conditioning (both terms are used here nontechnically) of anxiety, or at least not of anxiety of a greater degree than the organism can bear without special defences. Complete satisfaction can only be thought of in terms of time, and the time span of satisfaction varies from function to function. When Bion speaks of a realization of no breast available for satisfaction and sees this becoming a thought, it must take place within this limited time span. This time span controls the onset of the fundamental angst in living, the most primitive of the warning signals.

Complete satisfaction is no continuous state nor a stationary one, but like oxygenation, one that is maintained by continuous input of pulses of satisfying experience. In emphasizing the effects of bad object experience, I think Fairbairn is expressing in other terms the fact that perceived threat to our progression becomes in-built, because it is mediated or is seen to be, by a human object, and that splitting is necessary to cope with in-built unsatisfying and frightening objects. I think he tends not to emphasize enough the strength and momentum that is engendered by good experiences, which lead to ego strength, to the

capacity to surmount obstacles, the creativity, the artistic feats of reparation, the non-sick parts of the personality which are one's invariable ally in treatment.

Fairbairn believes that the dependence of the child is the root cause of later neurosis. I hope I have shown that it is not the dependence itself, but the fact that helplessness and therefore danger underlies it. Dependence securely borne is our most triumphant experience, the prototype of love. It is normally met and carried by mothering. The ethological evidence about this is not yet clear. We know a great deal about the need of an object to which some creatures can cling. There is some evidence that in the absence of suitable objects with whom some form of relationship can be enjoyed, it is well nigh impossible to rear some creatures in spite of adequate and correct feeding. If the mothering has been adequate, if expectations have been met, normal development ensues. The fact that we exist in time postulates some degree of memory and of expectation—the psychic counterpart of the physical continuum. This permits some delay. Indeed the capacity for delay in satisfaction becomes an important part of subsequent artistic experiences and the source of some of our greatest, but most sophisticated, pleasures. If first experiences go wrong anxiety and aggression are mobilized. They will be mobilized anyhow in life and sooner rather than later, but there are times when they can be more easily borne than others.

Probably man is not so very different from the jackdaws that Lorenz (1952) has so delightfully described. Their friendship could be lost for ever if their rattling attack was provoked two or three times, and probably an old guide jackdaw needs only to give one significant rattle on the appearance of an enemy to create in the young birds a mental picture of what is now from henceforth an enemy for them. Man does differ in the fact that so much less of his behaviour is based on blind and innate reactions and so much more on experience and learning. He does develop an inner object world, good and bad, which permits vastly greater change and freedom of choice. Nevertheless, innate and apparently irrational ways of reacting may have been alerted within us.

But the relationship of dependence and independence has to be considered further. Winnicott (1958) in many places has given a valuable check to ways in which mothers in particular have been too lightly blamed for causing their infants' mental sickness. He speaks of good enough mothering and the good enough environment. A perfect match is not required, our viability enables us to cope with a degree of failure, a degree which in some respects increases with maturity, though it must contain critical occasions. The mother's function is to hold her independent dependent infant, to assist its orientation to the external world, to provide an envelope in which it can develop, quite apart of course from feeding it. For the infant its psychic processes, its internalizations, are necessary in order to retain its independence. The molecules of its mother's milk may be built into its fabric because they are identical, but if its personality is to develop in healthy independence, an internal object world that is it yet not it must develop. I wonder if it is legitimate to suggest a parallel between this and the fact that its mother's protein acts as a foreign body. A bad internal world is one in which this individuality has been violated, in which confusion of boundaries exists. It can only be dealt with by pathological mechanisms, of which splitting and projective identification are paramount.

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Derivatives of anal erotism

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The definition of the anal character is taken from Freud (*Character and Anal Erotism* and *On Transformation of Instinct as exemplified in Anal Erotism*) and Abraham (*Selected papers on Psycho-analysis*). Freud noted how representatives of faeces in the unconscious could readily be interchanged with representations of a penis or a baby, and Abraham commented on the omnipotence of the child in the anal-erotic phase and that this omnipotence could be damaged too early and too much by unwise parental handling, so that obedience to social requirements could spring from fear of the parents rather than from love of them. Thus defiance—narcissistically toned aggression—becomes a feature of the anal character, along with pedantry and parsimoniousness. It was appreciated that in adult life anal characters could use money much as the child uses faeces to express feelings.

The material for this paper is derived from a study of seven patients who showed marked anal erotic traits.

Omnipotent feelings are experienced by the child with the realization of sphincter control-power expressed by muscular action. This omnipotence differs from yet is reminiscent of oral omnipotence. This experience of power is repeated over and over again. The faeces themselves come to be endowed with the power, and the exercise of the power may be associated with very varying feelings, so that faeces may present a love gift or hate and diarrhoea may express generosity or loathing. Faeces may also express compliance while refusal to give may indicate a refusal to modify omnipotence. A patient who was exceedingly short of money, received a legacy which he felt compelled to give to his mother. Oedipal as well as anal material was certainly present, and the Oedipal

reactions were modified by the degree of anal omnipotence which was still present. The refusal to modify omnipotence was expressed by another patient by saying that he felt 'sealed off'; that is, he felt he could do without the environment. Consciously, he felt remarkably powerless to modify in any way the uncomfortable circumstances in which he lived, for he retained the powerful faeces instead of projecting them, while complaining bitterly that he had lost all feeling. The same ideas of self-sufficiency were expressed in the phantasy of another patient who used to imagine that he lived in a house that stood in a garden, on a farm over a coal mine, and these gave him food, warmth and shelter, supplying every want. In the phantasy, remnants of oral as well as anal omnipotence were expressed. He had conquered the maternal breast.

Anality is seen in simpler form when a sudden frustrating experience produces regression. A female patient, the crux of whose difficulties consisted in the unconscious possession of a penis, had an unsatisfactory affair with a lover. He treated her badly and she became acutely depressed. 'I suddenly wanted to paint; I never had wanted to before. I bought some poster paints because, for some extraordinary reason, I grudged the money for oils. The yellow and the green colours fascinated me particularly. I found myself smearing them on; I liked to use a particular sort of paper and tore off sheet after sheet. The tearing of the paper and the smearing on of the bilious-looking paint was what I wanted to do. Then I tore up all the sheets and put them away.'

The connexion between muscular exertion and relief of instinctual tension persists in these patients. They are aware of the comforting effect for them of violent exercise. One patient used to go for long walks 'subduing hills'.

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Here also there were remnants of oral as well as anal omnipotence with discharge of aggression and also phallic omnipotence for this patient equated in the unconscious the foot with the phallus. Another patient used to find a round of golf particularly beneficial. His aggression was such that he could play no game in which he had to face an opponent, but golf he could manage. He had a round with the instructor, played well and felt almost elated, but when he came back to the clubhouse he was reminded by the instructor that he had failed to pay his subscription. He felt at once 'utterly defeated' and his 'limbs dragged'—his omnipotent feeling was challenged by an authority figure, his faeces were demanded of him, he did not comply but cathexis of the muscular system was not maintained and he inflicted a narcissistic wound upon himself. Here again Oedipal and phallic material as well as anal appears. This was the patient who described himself as 'sealed off'.

Speech—the giving of magic words—in the sessions may represent faeces and silence constipation, with regressive cathexis of the mouth. Utterance may have a characteristic explosive quality. In fact, one patient complained of having 'bouts of verbal constipation and bouts of verbal diarrhoea but no regular motions'. The same thing could be seen in all to some extent. None of the patients had a continuous speech impediment but one had had breath-holding attacks in childhood. A good deal of work was done on them. It was found that the mouth represented the anal sphincter and that a conflict was going on about retaining the contents or letting them go. In the end, of course, they had to go and this was felt to be a defeat. Instinctual discharge had become unpleasurable. The attacks alarmed the parents and this produced some secondary gain but was alarming to her as well. There were memories of being hung upside down and of being shaken. Attempts to prolong omnipotent control ended in narcissistic wounding.

A further extension of this sort of situation may be seen in material supplied by another patient. He behaved like the patient who was 'sealed off', in a passive and correct manner. He had no zest in life, no feeling of achievement. He had a conviction that the only thing that mattered in life was power, and as he felt he had none he was continually on the outlook for slights from superiors and was quite careless of the feelings of others if he did not think he would be made to suffer for it. In work he could show no initiative and when at leisure his time was spent in day-dreams of vanquishing enemies who were never visualized but who were in the last resort his parents. It seemed that the ego ideal and the super-ego had not been brought together and that this had interfered with the identifications with others that would have limited his sadism.

The confusion between faeces and penis can sometimes be seen very clearly. I shall give two examples. A patient dreamed that he was fishing for rock cod and the thing about those fish was that they were red-brown outside and had very white flesh inside. The scene was set in his childhood, a stream of water flowed by and parental figures stood behind him. Another patient had a vivid recollection of being taken into a lavatory by his aunt when he was a young child to urinate. She stood behind him and threw the stub of her cigarette into the water. It swelled up and burst and shreds of faeces-like material swam out as if they had a life of their own. Oral, anal, phallic and Oedipal material appear together.

During the phase of anal-sadism, with the growth of muscular power, attention is directed to the periphery of the body. Faeces appear as a peripheral something that falls off. Many children think that a finger has fallen off between the index and the thumb. Theories of cloacal birth lead to the assumption that the baby has fallen off like a stool. When these phantasies appear in the material produced by patients, smells and colours seem to be important as connecting links. In the absence of experience, similarities are put together in a way we do not expect. A boy, who had a brother five years younger than he was, expected that his mother would have another

baby when he was ten because babies were like stools and should therefore come as stools should come at regular intervals. He also said the baby smelt of faeces and looked yellowish. A woman thought her daughter of eighteen looked bilious and 'smelt bad' and kept telling the girl to wash more.

Anal material is often expressed in references to hair. Hairs may stand for a stool hanging from the body, and are often used to express the connexion between faeces and penis, in fact the possession of hair is commonly thought of as a sign of virility in men. A neurotic dread of baldness is present in two of the seven patients. One noticed that when he became troubled by doubts of his own potency, he also started to worry about his hair falling out.

It has been stated that the child may accommodate to social demands either through fear or through love. One can now see how much more difficult it is to abandon omnipotence from fear than from love, and how greatly this increases the child's anxiety. If the child has no loving authority on which to rely, he readily becomes anxious about losing bits of himself and clings possessively to them, and the boy becomes anxious about losing the penis he can see and feel, while the girl clings to the idea of having lost part of herself or elaborates the phantasy that she still possesses an equivalent organ inside. Sexual differentiation becomes a matter of anxiety. Further, the penis may be thought of as a nipple, leading to omnipotent phantasies of self-sufficiency, or the nipple of the mother may be thought of as a penis.

One must also recognize that the faeces may represent the mother who is extruded. Two patients in this series showed this clearly and those phantasies were associated with phantasies of incorporating the mother again —eating faeces. Both patients experienced attacks of terror and the basis of these seemed to be a rapid introjection and projection as a last defence against a feeling of disintegration. This cycle is felt to be inevitable and also terribly tiring, for the patient cannot escape from his own aggression for he keeps internalizing it.

Analysis of these patients allows the therapist to see an internal situation involving introjected objects being acted out in terms of constipation, diarrhoea, flatulent distension and colic. Once this is grasped, one is in a position to appreciate the weakness (ego weakness) of which they all complain.

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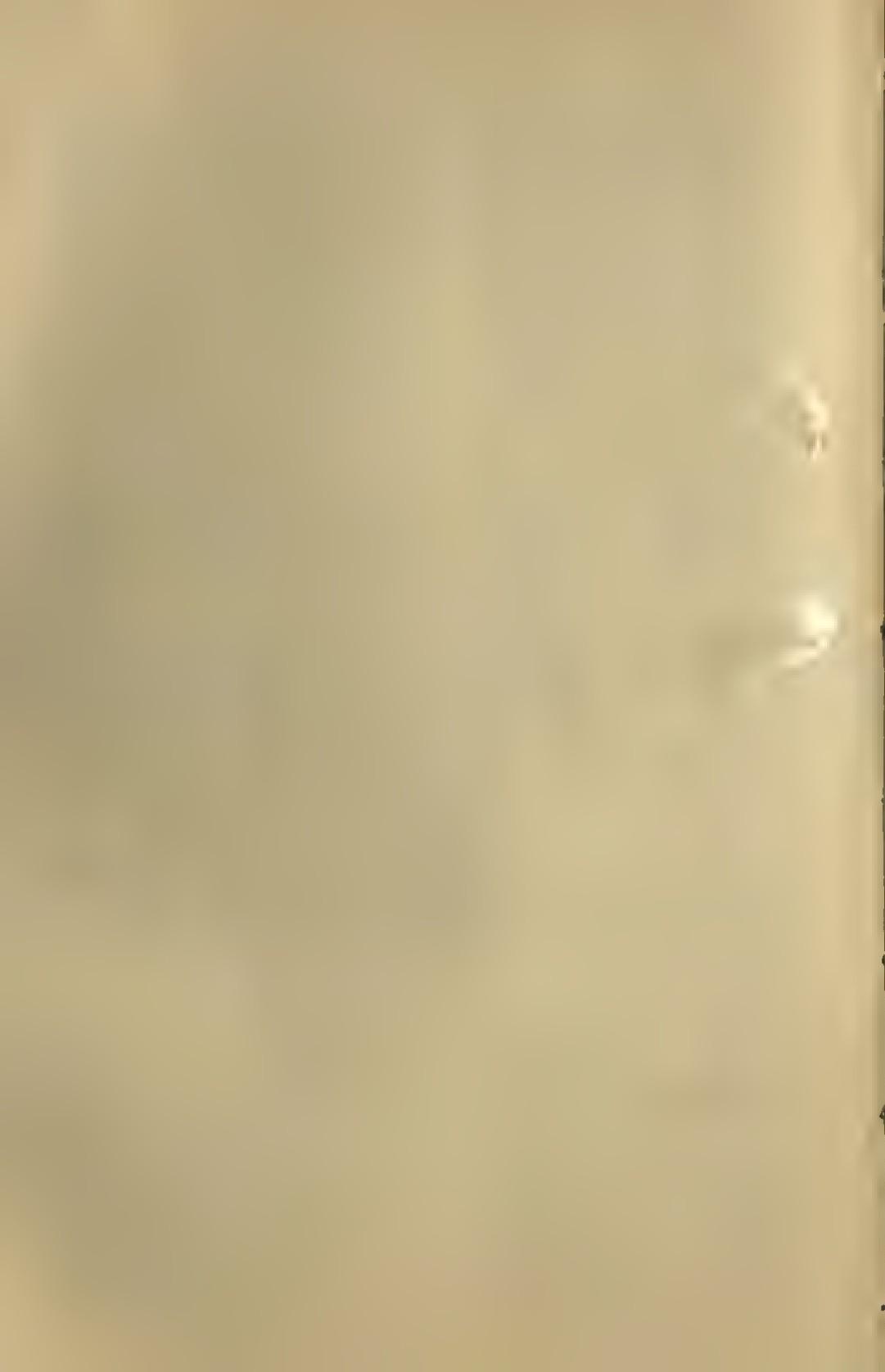
Fairbairn's contribution on object-relationship, splitting, and ego structure

By J. O. WISDOM*

INTRODUCTION

The opportunity to give special attention to Fairbairn is welcome because he is an unusually good writer, because he presents a case in a living way—one even scents the air breathed by Conan Doyle—but chiefly because he has given considerable thought to theoretical work and developed it with lucidity. Whether Fairbairn's theory is right or wrong, the intellectual qualities behind it make it worth studying.

I propose to discuss issues arising out of his theory. No didactic exposition of his point of view is needed, since he has himself published excellent accounts of it (Fairbairn, 1952) and a faithful rendering has been given by Guntrip (1961). It will be possible to proceed to a detailed statement of the central contentions.

Fairbairn's main theory consists of the following: (1) Theory of universality of object-relationships. (2) Theory of the schizoid position. (3) Theory of dynamic structure: the mind as three egos.

(1) THEORY OF UNIVERSALITY OF OBJECT-RELATIONSHIP

This consists negatively of—

Hypothesis (1 *a*): there exists no libido.

Hypothesis (1 *b*): there exists no id or storehouse of libido.

Hypothesis (1 *c*): the pleasure-principle, which the libido classically obeys, is false.

Hypothesis (1 *d*): pleasure is not sought in a definite bodily zone.

And it consists positively of—

Hypothesis (1 *A*): there exists an ego with libidinal aims.

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Hypothesis (1 *C*): the ego, while welcoming pleasure, is not pleasure-seeking but object-seeking.

Hypothesis (1 *D*): objects are sought through the channel of a definite bodily zone, or, otherwise expressed, definite bodily zones afford techniques for seeking objects.

The issues here concern ego structure, a regulative principle, and the role of zones.

Some interim comments may be made.

(i) Despite his general clarity, Fairbairn does not make his position about the pleasure-principle entirely clear. He holds that it does not dominate, but that object-seeking does. He is not, however, out to decry the importance of pleasure: he does not deny that the ego is pleasure-seeking but asserts that it is not *primarily* pleasure-seeking. This would seem to mean that the search for an object will press on even at the sacrifice of pleasure or at the cost of unpleasure, and that only when objects are equal in estimation is that one preferred that affords the greatest pleasure. This may or may not be true, but it needs to be brought out.

(ii) It is at least a theoretical possibility that all object-seeking is subject to pleasure-seeking as an underlying principle. Let us recall that Newtonian dynamics practically all hinges on a law connecting force and acceleration. This did not prevent others, such as Lagrange, from re-arranging the structure of the theory. It can be based, for example, on the principle of 'least action', which is in a simple case that the product of the energy and the time is constant. Now no one thinks that a particle must obey *either* the law of force *or* some such principle; it obeys the law of force but in the course of doing so its motion satisfies the principle. Likewise it *might* be that an ego always seeks an object, but that its

activity always satisfies the pleasure-principle (the analogy with dynamics, however, need not hold, i.e. the question is open). Hence, as an alternative to holding that the ego seeks an object irrespective of pleasure and unpleasure, Fairbairn might have retained the pleasure-principle as compatible with and underlying object-seeking. In fact I do not think that the principle of least action is the proper analogue, but rather that of the conservation of energy, which I shall discuss later, but the difference does not affect the point made here.

(iii) It was, therefore, not necessary for Fairbairn to bring in the question of the pleasure-principle. His theory can stand or fall without doing so. (To bring it in was, of course, a natural thing to do in the interests of telling exposition.)

(iv) The assertion of his zone hypothesis is a natural consequence, though not a strictly necessary one, of denying that libido flows from the id. One could, however, both adopt Fairbairn's zone hypothesis and retain the classical id-libido hypothesis in a modified form. Suppose, for example, that the libido flows through an ego that acts as a sort of filter, so that the outcome is libidinal ego activity. Then the classical zone-hypothesis would have to be given up and replaced by Fairbairn's; and yet the ego would rest upon an impersonal id, as a tree with relationships to its environment draws impersonal chemicals from the soil round its roots, or as a car might be said to have a relation to other objects on the road while the petrol that gives it its impetus has none.

(v) Fairbairn's first objective is object-relational manifestations. So long as all human actions are object-relational and none is purely pleasure-seeking without respect to object, he has what he basically contends for; it would not matter to this viewpoint if the sap of the ego rose from some impersonal sump. Certainly if Fairbairn could refute the id-libido hypothesis, he would virtually have his zone hypothesis established; but it might be possible to establish this hypothesis by other means than by refuting the id-libido hypo-

thesis. If it is possible to do this, a question that will be discussed below, it follows that the classical id-libido hypothesis, or at least one part of it, is false.

These interim comments are intended to sort out what is essential to Fairbairn's position; the real task, of course, will arise when we come to consider evidence for or against ways of establishing or refuting the essential part of his theory.

(2) THEORY OF THE SCHIZOID POSITION

Fairbairn places great emphasis on the role of schizoid mechanisms in all mental functioning. Their importance can hardly be exaggerated, as many analysts would now agree; but, it may be remarked, they may owe something of this knowledge to Fairbairn—he was the first in the literature to give them a place in the centre of the stage. He showed that they play an important part not merely in the psychoses but also in the neuroses. In consequence they must have a fundamental bearing not only on therapy but also on theory. Since schizoid processes antedate integration, we encounter them if we investigate the earliest stages of mental development; hence, if we wish to arrive at the origins of psychic structure, we must study schizoid processes.

Fairbairn's theory of the schizoid position involves the following hypotheses—

Hypothesis (2a): the primordial ego is confronted with an undifferentiated object, qualified as neither good nor bad (this he calls the 'pre-ambivalent object').

Hypothesis (2b): the pre-ambivalent object is not subjected to introjection.

Hypothesis (2c): as soon as the pre-ambivalent object disappoints, when it is said to be 'rejecting', the ego splits it into two pieces, one regarded as good and one as bad.

Hypothesis (2d): the bad object is then introjected. (This amounts to saying that the primary introjection is of a bad object only.)

Thus far the 'schizoid position' refers to a splitting of a pre-ambivalent external object into good and bad parts, followed by the intro-

jection of the bad part. This has to be amplified by noting that eating is intrinsically linked with this, for eating an external object, however lovingly, can be felt to split it and to turn bad the part that is just about to be taken in. Thus the schizoid position is an oral destructive position and carries the consequence:

Hypothesis (2 e): the schizoid position involves a sense of destroying by loving.

This intolerable strain is handled by—

Hypothesis (2 f): the ego becomes split.

Thus the schizoid position is characterized by splitting the external object, introjecting a bad object, having the sense that this object had been made bad by loving, and splitting the ego.

It is necessary for reasons of clarity and assessment to contrast this notion with that of Melanie Klein's 'paranoid-schizoid' position (Klein, 1946). She began by calling it the 'paranoid' position, but considered that it essentially involved something of the process described by Fairbairn, and therefore she adopted his term but coupled it with her own. The compound correctly describes her view,[*] but it must be borne in mind that 'schizoid' as Fairbairn conceived it in the 'schizoid position' was not wholly identical with what she meant by 'schizoid'. To make the contrast clear, I will now try to state Melanie Klein's theory. This is especially necessary because no explicit statement exists and because, unlike the theory of the depressive position which is relatively simple (which I (Wisdom, 1962) have attempted to state in detail elsewhere), this theory has its difficult features.

I will begin by stating roughly the main ideas involved. There is a background theory about the functioning of instincts and a foreground theory about mental processes. For Melanie Klein these were interwoven; but it is possible, and even desirable, to separate them conceptually. The background theory is to the effect that there are two biological instincts that are manifested in the mind as phantasies (Isaacs, 1948); one is the life-instinct whose psychical manifestation forms a good object; the other is the death-instinct, whose manifestation forms a bad object. And, further, the instincts can act upon these objects. Once these objects are formed mental processes develop broadly speaking as follows: (a) in the very first object-relationship of an infant, the ingredients of the ego and the object occur sporadically, i.e. good and bad parts are not felt together; this may be described as 'the sporadic state'; (b) a certain factor promotes union of good and bad parts; (c) when some degree of union does take place, splitting processes restore the sporadic state; (d) the chief consequence of splitting is projection of aggression, which leads to persecution (a somewhat similar process leads to idealization); but in contrast to this malignant cycle there is a different process; (e) when some degree of union in the ego takes place without being immediately split, union of the good and bad parts of the object ensues, thus giving rise to a benign cycle—which, however, is unstable until the depressive position is under way. The basic questions that arise concern the nature and mechanism of the splitting and unifying forces.

There are certain preliminary knots to disentangle. In the state (a), where the components are sporadic, as it were by nature, no 'schizoid' or 'paranoid' process is required to bring it about. Again, the state (c) involves union, and therefore may seem to be no different from the core of the depressive position. Neither state would then be paranoid or schizoid. What, then, do these terms refer to?

These difficulties are fairly easy to resolve. There is an essential difference in conception between such union as occurs in (b) and the integration characteristic of the depressive position. In the state (c) of the paranoid-schizoid position, the ego refuses at the first sign of pressure to accept union and breaks it up. In the depressive position, however, the

[*] It does not, of course, mean that the infant has paranoia and schizophrenia but that he has a structure characteristic of these disorders; the terms are given a rudimentary sense somewhat as Freud did with the term 'sex' when he applied it to childhood.

ego accepts both good and bad objects as stemming from one person, and in accepting integration is trying to tolerate the guilt of ambivalence; and failure to do so leads to defences against such feelings, but not, unless the depressive position gives way, to disintegration of the object. The essential point that marks the transition from the paranoid-schizoid position to the depressive position is the growth of the capacity for reparation. Once rudimentary reparation is possible, the depressive position is entered, and the infant's problem is how far can he repair destruction or defend himself against guilt if reparation is not secure; without this mechanism he can only regress to splitting.

The sporadic state (a) may be seen to be a limit approached, but never or seldom attained after some degree of union has occurred; for unifying processes almost always gain the upper hand. The state (a) might be said to characterize the moment of the first object-relationship. Thereafter it would be a position that splitting processes in the state (c) would tend to restore. Thus the use of the term 'schizoid' in the paranoid-schizoid position refers not to the initial sporadic state but to a subsequent process of splitting states of rudimentary union. Moreover, since the ego reverts to the sporadic state, a split-off bad object becomes projected and attacks the ego, so that the state is also paranoid.

Does the rudimentary union arise to obviate persecution or does splitting (and hence persecution) arise from the strain of union? In the very first instances of union and persecution, the possibility of accepting the strain of union in order to forestall or nullify persecution would be ruled out by the primitiveness of the state of mind being considered. Afterwards such a process could well come into being as an auxiliary. It would seem that in the very first instances splitting must arise from the intolerable strain of union within the ego.

The main question is: what induces union? Arising out of this is the question: what destroys union? Connected with this is the question of which object gains control. But there is also a question of priority: does union develop initially in the ego and pass to the object, or initially in the object and pass to the ego (simultaneous development is hardly a realistic alternative)?

The broad idea in Melanie Klein is that the malignant cycle is due to the infant's bad objects overpowering his good ones and that in the benign cycle it is the other way round; she seemed to view this both as a quantitative and as a qualitative phenomenon; but she offered no suggestion about how it works. The reason why there is a problem here is this. Intuitively one can understand that if one has a number of good objects one can feel not too upset by a bad one; but this would not explain how good and bad objects that are totally unconnected could be experienced together at all. I think, therefore, that we have to presuppose a differential unifying tendency (which I shall not examine in this paper but intend to investigate on another occasion), i.e. that the infant can experience life in terms of good objects with a very small admixture of bad ones, so that there is only a small amount of strain. Further, anything that increases the power of the good objects will make the bad ones more tolerable and increase the capacity to tolerate more bad objects; and likewise anything that increases the power of the bad objects will increase strain beyond toleration and necessitate making a split between the good objects and at least some of the bad ones.

Connected with this is the question: what determines whether the good or bad object will gain the ascendancy? There are two possibilities. One is that union is brought about by the life-instinct and splitting by the death-instinct. The other possibility lies in the ebb and flow of environmental influence. Thus when an infant's mother picks him up in a schizoid state with persecution, cuddles him, and quickly makes him feel all right, what presumably happens is that she is nuclearly introjected and thus reinforces the good

objects in the nucleus.* None the less, the theory is endopsychic: the process arises in any mind confronted with any human environment. But the environment makes a colossal difference to the outcome of the process. A coal fire burns in any environment containing oxygen, and a chain reaction is set going which is an internal mechanism; but a little sand or too much coal will greatly impede the functioning of the fire, while a little coal placed with discretion will foster it. Likewise, good-object promotion or good-object neglect on the part of a parent may determine whether the benign or the malignant cycle becomes the more entrenched in the personality. Melanie Klein would hold that both are determinants, and that they usually combine, but that, even in the absence of the environmental influence, the instincts can act independently to produce union and splitting.

The paranoid-schizoid position might well be described as the benign-malignant cycle.

To turn to the last question of where union first arises, suppose it takes place first between good and bad orbitals rather than in the nucleus of the self, i.e. that a good orbital makes a bad one more tolerable. It is hard to see how this might induce union in the nucleus (whereas it is easy enough to see how the reverse could happen). Moreover, union of orbitals would diminish persecution by the bad orbital (contrary to what the theory requires).†

* I have found that it makes for clarity and precision to describe the structure of the self in terms of nucleus and orbitals (Wisdom, 1961, 1962, pp. 115–16). Roughly, orbitals are objects in the inner world confronting the nucleus or core of the self.

† Further, prior to the division of the self into nucleus and orbitals, which would be in effect the formation of orbitals, all would be nuclear. Hence, provided—what seems to me likely—that the union of good and bad objects occurs not later than the formation of orbitals, it would be nuclear in the first instance. I do no more here than mention this as a possibility; to be a firm argument, considerable further justification would be required.

We are now in a position to put our ingredients together. Given the formation of good and bad objects by the operation of the instincts, we may describe the paths of the cycles as follows.

(Paranoid-schizoid Position i) When the first object-relationships come into being, good objects are experienced separately from bad ones, and a good part of the ego does not enter into experience at the same time as a bad part. (P-s P ii) When the good part is sufficiently good, a tentative linkage with a small bad part is tolerable, and a rudimentary union in the ego (nuclear union) is formed. (P-s P iii) If undisturbed, this both strengthens the ego and leads to the formation of an object (orbital introject and external object) that includes both good and bad parts. (P-s P iv) This situation, however, gives rise to guilt, against which at the beginning there is no defence—as later by reparation. (P-s P v) Because defenceless, the strain in the ego-union (nuclear strain) increases; that is to say, the bad part of the ego is felt to be in control, because, on the instinct theory, the death-instinct is felt to be dominant. (P-s P vi) The strain is removed by splitting the ego (nucleus), which again, on the instinct theory, is effected by the death-instinct. (P-s P vii) In consequence the object (orbital introject and also external object) is also split. (P-s P viii) To obviate the possibility of strain from the presence of the bad part of the ego (nucleus) it is projected on to the bad object (orbital introject and external object), which then persecutes the good part of the ego (nucleus). (P-s P ix) Parallelwise, the good part of the ego (nucleus) may be projected on to the good object (orbital introject and external object) to protect it, so that the good object (orbital introject and external object) is idealized (a rudimentary manic defence). (These projections, being of a part of the ego, constitute projective identification.) (P-s P x) This cycle may be broken by introjection as a result of parental help, or, on the instinct theory, by the operation of the life-instinct. (P-s P xi) The good part of the ego becomes strengthened enough

to tolerate the bad part. (P-s P xii) Hence the projections are nullified, and the object is unified once more.

The cycles may be depicted thus: good part of nucleus dominates bad part → nuclear union → orbital union of good and bad introjects → guilt → nuclear strain → splitting of nucleus

$$\left\{ \begin{array}{l} \rightarrow \text{projection of destructiveness} \rightarrow \\ \rightarrow \text{projection of goodness} \qquad \rightarrow \end{array} \right.$$

$$\left. \begin{array}{l} \text{persecution} \\ \text{idealization} \end{array} \right\}$$
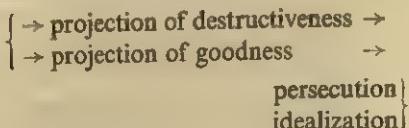
→ rescue by environment → good part of nucleus increased → ....

The change from one cycle to the other and back again continues at least until the process of reparation develops with the depressive position (though this process cannot come into being if the malignant cycle seriously dominates). The difference between idealization and reparation is that idealization may be regarded as the projection of a good part of the ego on to a split object (and therefore is akin to narcissism), whereas reparation may be regarded as the projection of a good part of an ego with good and bad parts integrated together on to an object that the ego recognizes it has damaged. The benign-malignant cycle runs, I would estimate, from the first few days to 4 months. Melanie Klein puts it at or near the beginning of life.

Although discussion of Melanie Klein's theory would take us too far from the theme of this paper, it is well to mention the methodological importance of separating the instinct theory from the clinical theory of the processes making up the benign-malignant cycle. These processes may be clinically tested, but there could be a variety of explanations for them, of which the instinct theory would be one candidate. Otherwise expressed, the two theories are on different levels and can be discussed independently. It is therefore important to state the theory of the paranoid-schizoid position in such a way that the instinct theory is detachable from the theory of the cycles.

I have been attempting to construct the theory of the paranoid-schizoid position from the not fully explicit accounts given by its inventor. Most of the ingredients are in her publications. But it has to be understood that, in attempting to trace the cycle in detail and therefore in attempting to answer questions she did not mention, the result is bound to be in some degree a rendering of her theory and not literally her theory. Thus when one considers one of the great earlier discussions of motion in physics one may render motion by momentum, and probably rightly so, but it is none the less a rendering. My concern, in piecing together Melanie Klein's theory of the paranoid-schizoid position, has been to render it accurately and in a form that distinguishes function and dysfunction, clinical and conjectural processes, and non-clinical postulates.

Fairbairn's idea of the schizoid position might be further elaborated in a somewhat similar way; for, after the primary introjection of a bad object takes place, a good object is introjected to alleviate the situation. But there is an essential difference. For Fairbairn, the primary introjection of a bad object results from a *disappointing* experience in which the external object is felt to be *rejecting*; no projection, and therefore no projection of aggression, is—on Fairbairn's account—involved. For Melanie Klein, a rejecting object has no significant effects unaided, but only if the subject reacts to the rejection with aggression which is projected on to the rejecting object, thus rendering it bad or persecuting.

Thus when Melanie Klein embodied Fairbairn's term 'schizoid' with her own, this may be ascribed to her recognizing the role of splitting in a very general sense. But her acknowledgement to him is misleading in that it may suggest that the term has the same meaning in both theories. There is, however, a prior introjection of a bad object, according to Fairbairn, while there is a simultaneous introjection of a good object and a bad object, according to Melanie Klein; hence 'schizoid' for Fairbairn really does mean splitting in the full sense of splitting an already existing whole, whereas for Melanie Klein it refers to a

tendency to resist integration processes. But the main difference between the two theories is that Melanie Klein's essentially involves aggression, projection, and persecution, whereas in Fairbairn's theory these play no part—so far as concerns the very first psychical process.

Since Melanie Klein's theory has more content, it might seem either that some of its components are redundant or that Fairbairn's is too thin to do the work required of it. This may be true, but does not immediately follow, for the nature of the splitting of the ego might make good any deficiency, if there is one; besides Fairbairn's theory of ego splitting theoretically should form part of the theory of the schizoid position and would have been included above were it not that it is not just another small component but a large subdivision which needs a section to itself.

(3) THEORY OF DYNAMIC STRUCTURE: THE MIND AS THREE EGOS

Fairbairn's tripartite division of the self, which reflects the function, though not the structure, of Freud's id, ego, and super-ego, is brought about by normal schizoid processes. His conception of the structure involved stems from the theory that object-relations are universal or that there is no id pouring forth libido that is solely pleasure-seeking. There are certainly libidinal processes; but, since they are object-seeking, they cannot stem from something impersonal; on the contrary, their source must have the character of an ego. In short, the immediate consequence is—

Hypothesis (3*a*): there exist libidinal ego processes. Likewise there are processes that interfere with these, which for Freud constitute the super-ego. Unlike the id, the super-ego is personal, so Fairbairn makes less change here (he makes some difference but it is not relevant at this point). So far, however, the opposition to libidinal processes gives only the consequence—

Hypothesis (3*b*): there exist antilibidinal ego processes.

Now when an external object is rejecting, aggressive ego impulses come into play—initiating the schizoid position—to split the object, libidinal ego processes willy-nilly introject the bad object, which is felt to owe its existence to the libidinal ego demand for a good external object. There is therefore a strain between the aggressive ego impulses and the libidinal ego demands. This, in altered terms, represents the situation in which the description of the schizoid position above was left. We now have additionally—

Hypothesis (3*c*): aggressive ego impulses turn against libidinal ego demands, and thus become antilibidinal ego impulses.

The strain produced is eased by splitting the antilibidinal ego impulses from the libidinal ego demands.

Hypothesis (3*d*): splitting constitutes libidinal ego demands into a libidinal ego and antilibidinal ego impulses into an antilibidinal ego.

Illustrating with good examples, Fairbairn claims that libidinal egos and antilibidinal egos are clearly represented in dreams, and he points out that we must not overlook the observer of these egos, the 'I'. Hence

Hypothesis (3*e*): the libidinal ego and the antilibidinal ego presuppose, and are in fact found to be observed by, observing ego processes.

Hypothesis (3*f*): these observing ego processes are split off from the two egos observed and therefore themselves constitute an ego, which is known as the central ego.

The three ingredients of the self, consisting of central ego, libidinal ego, and antilibidinal ego, constitute what Fairbairn calls 'dynamic structures' of the mind. What this means is first that each ingredient is a structure, as contrasted with the id which is not; and second that, while the idea of a structure usually suggests a container not itself active, here the structure is dynamic. A reservoir is not a dynamic structure but interstellar dust or a star or a coal fire is.

It is pertinent at this point to mention the place of internal objects in a dynamic structure. The three egos form what I have called a

nucleus and introjected objects form what I have called orbitals confronting it. Orbitals, for Fairbairn, are not primarily dynamic structures; that is to say, to avoid confusing the exposition of his views he treats them as if they are not; but he gives more than a hint that they should be expected to be both dynamic and structures, though he does not develop the point. In Melanie Klein's theory they plainly are dynamic (though their dynamism is imported from the nucleus) and at times seem to have a rudimentary structure (as in the imago of the combined parent-figure).

The contrast between nucleus and orbital enables us to understand that, for Fairbairn, the antilibidinal ego is a component of the nucleus and is not, as Freud's super-ego is for the most part, an orbital.

Fairbairn retains the word super-ego but hardly the concept: he uses it for an orbital that is the conscience, which he regards as part of Freud's concept of the super-ego. This, I think, is misleading: for Freud conscience is a conscious layer of the super-ego and a product of its wider sadistic repression of the libido. Conscience is the least dynamically significant part of Freud's super-ego, and it is unfortunate to restrict the use of the word accordingly. The basic dynamic function of Freud's super-ego is the same as that of Fairbairn's antilibidinal ego.

But Fairbairn *replaces* the id-libido by a libidinal ego. It is theoretically possible to have his three egos as a horizontal section and still retain the id and various egos as a vertical section. This might be unsatisfactory, but Fairbairn has done nothing to disprove it; he seems to assume that the theory of the universality of object-relations makes the replacement of id-libido by libidinal-ego automatic.

(4) FAIRBAIRN'S CONSEQUENTIAL VIEWS

Fairbairn derives a number of consequences from his theory, which are interesting in themselves and which should be noted even though discussion must be reserved for the more central parts of his theory.

(a) He allots a specially important role to identification of the ego with an object—what I have called nuclear identification—for he uses it to discriminate normality from neurosis. (Strangely, he regards this identification as constituting primary narcissism.)

(b) He gives a revised psychopathology, in which the type of disorder that arises depends upon what kind of object is introjected and what kind projected.

(c) The schizoid position is characterized, in his view, by the phantasy of destroying the good object by love while the depressive position is characterized by the phantasy of destroying the good object by hate.

(d) He considers that repression is directed not against impulses, libido, id, or memories, but against objects, and that it is a consequence of splitting.

(e) He also denies, consonant with his denial of the pleasure-principle, that dreams are wish-fulfilments (presumably even that they are attempted wish fulfilments), and regards them as 'shorts' depicting the inner state of mind. Professor R. O. Kapp (1962) made the comment to me that in Freud the dream had a function, to preserve sleep, which practically forces the wish-fulfilment theory on us, and asked what, if anything, is the function of the dream for Fairbairn. I suppose the reply might be that the function is the same but the means different, i.e. the dream provides the sought objects. This would of course imply wish-fulfilment, though in a new sense, for it would be the fulfilment of a wish for certain object-relationships and not of a wish for libidinal pleasure; it would therefore run counter to the classical theory of wish-fulfilment. It is extraordinarily difficult to find a way of deciding this issue.

(f) He disputes the priority of aggression and holds that it comes into play only as a result of frustration and not prior to it as with Melanie Klein.

(g) His view of personality, as contrasted with that of Freud or even of Melanie Klein, assumes a different hue.

I propose to leave these without comment and to confine discussion to the basic issues of Fairbairn's theory.

(5) Discussion

(i) *The id-libido theory*

It was indicated above that the existence of a libidinal-ego does not necessarily render otiose the idea of libido flowing from its sources in the id, canalized through the libidinal-ego, to a sink* in the ego's object. Whether or not the idea should be retained depends upon the role ascribed to it. For Freud, its role was large and complex, and it would be foolhardy to scrap it without making sure that its original functions are taken over by something else. Thus the idea in Freud had a dominating place in the quantity theory of psychical energy, and therefore in the theory of displacement, sublimation, and symptom-formation, in the theory of inhibition and repression, in the theory of fixation points, and in the theory of primary and secondary narcissism. It would be impossible in a single paper to go into so large a matter, which in effect involves the general theory of normal psychical development and the general theory of the neuroses, all the more as even the classical theories have never been stated with the degree of precision required for a decisive discussion. I do not mean that we are chained to Freud's theory; I mean that if we decide to scrap it, we should know what else has to be scrapped along with it. We may find, however, that the issue concerning the classical form of the theory can be settled indirectly after we have considered the zone-hypothesis. Meanwhile we may note that what is significant in Fairbairn can survive with, as well as without, this theory.

(ii) *The zone hypothesis*

The classical zone-hypothesis may be put like this: that libido floods one of the three zones, oral, anal, or genital, and seeks pleasurable discharge; whatever object happens to be made use of to achieve satisfaction is of no account, i.e. the ego is indifferent to the individuality of the object and is concerned only that it should facilitate discharge.

Fairbairn, on the other hand, denies this *in toto*, to the extent of denying that id-libido enters into object-relationships. His view is epitomized thus: it is not that adequate genital sexuality promotes mature object-relationships, as the classical theory implied, but the other way round.*

Balint (1932, 1957), who first stressed the over-riding importance of object-relationships, none the less pointed out against Fairbairn that proof of their universality was lacking. Balint argued that the evidence we have bearing on the question is clinical material, essentially transference material: that is to say, what we have clinically is always necessarily object-relational, so that we do not know what happens in an isolated ego, whether or not it aims solely at zone satisfaction.

What, in fact, is the relation between clinical observation and the zone hypothesis?

The classical idea was that if there was fixation on a zone, symptoms would be a direct manifestation and disturbed object-relationships a consequence; to improve the object-relationship it was necessary to undo the fixation or remove the symptoms. But, as Balint implied, the classical method was always, and necessarily, to analyse the symptoms in relation to the transference and therefore to analyse the object-relationships. When these improved, it was concluded that libido had been freed from fixation on a zone. Yet the clinical changes constitute no evidence for the hypothesis that zone-fixation causes symptoms or disturbances in object-relationships—

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* 'It is not in virtue of the fact that the genital level has been reached that object-relationships are satisfactory. On the contrary: it is in virtue of the fact that satisfactory object-relationships have been established that true genital sexuality is attained' '...the real significance of the "genital" stage lies in a *maturity of object-relationships*, ... a genital attitude is but an element in that maturity.'

* Sources and sinks are terms used in hydrodynamics.

if anything it would be the other way round—or even that zone fixation in the classical sense exists. But mere absence of evidence does not provide disproof.

Is there any way of taking a further step? It would seem that a consequence can be deduced from the classical hypothesis: namely, that if by hook or crook we can remove a symptom, then this must mean that the libido has become detached from the zone, and therefore object-relationships should improve. For example, if a man is fixated on the phallic zone and this is manifested as impotence, then, according to the classical theory, he cannot develop a mature relationship with a woman. Now if by some device such as a drug—and now at last there appears to be one—he could be made, at least for a time, potent, then it should follow that his relationships with women should grow more mature. So far as can be judged from cases of temporary relief from symptoms, there seems to be little indication of improved object-relationships. In certain cases we might expect to find some improvement, namely, where the symptoms have an upsetting effect upon others; for the temporary abatement of such symptoms would make these others more friendly towards the subject, who could therefore mature somewhat in his relationships to them. This idea lends itself to testing. If we found that abatement of the class of symptoms that are socially trying to others led to improved object-relationships and the abatement of the class of socially neutral symptoms did not, we should have definite evidence telling somewhat against the classical zone hypothesis—made much stronger if improved object-relationships led to abatement both of the socially trying and the socially neutral symptoms.

Lacking this test, we are left with the fact that the method of improving object-relationships improves symptoms, which even by itself is evidence against the zone hypothesis.

It would follow that the id-libido hypothesis is, in its classical form, false (though some modification of it might be true).

It is an interesting reflexion that Freud's theory implies the theory of conditioning, whereas the object-relationship theory points in the psychosomatic direction.

(iii) *The pleasure-principle*

The pleasure-principle occupies a curious place in psycho-analytic theory, which makes it in one fundamental respect like the law of the conservation of energy in physics. It is worth drawing attention to a peculiarity about the latter which makes it perhaps unique in its field.

As is well known, Popper has characterized scientific statements as being empirically refutable. Now there are some statements that *may* not be *known* to be refutable, such as those of general relativity had there happened to be no moon and no planet Mercury; such statements, which are in fact refutable, may be thought to be irrefutable but *cannot* be *known* to be. A statement once irrefutable in the then state of knowledge can become refutable when someone thinks of a test for it. There is, therefore, a distinction between statements for which no possible refutation has been proposed and those for which a method of refutation can be specified.

Consider those statements for which no possible refutation has been proposed. Some of them cannot be known to be irrefutable, and we might over-readily suppose that all are in this position. But this is not so; some are irrefutable in principle. Since there are examples of these that form part of science, they apparently run counter to Popper's characterization of science. They are of major importance also in other ways, as will appear below.

An example from physiology is: 'All bodily changes are due to physical causes' (Wisdom, 1956, p. 25). When a bodily change occurs for which no physical cause is known, this is not accepted as a refutation—rightly because for there to be a counter-example there would have to *be* no physical cause, and this is not established by no physical cause being *known*. It is characteristic, as Popper (1959) first showed, that an infinitely wide (in space) and long (in time) search for the required physical cause

can be carried on: predictions consist of purely existential statements which, as Watkins (1958, pp. 345–7) has put it, assert the existence of something that is neither circumscribed nor localized by any boundary. Since these might be verified but could never be falsified, the law in its turn might be verified but could never be falsified.

Similarly in psychology, the doctrine of epiphenomenalism, 'All mental changes are due to physiological causes' (Wisdom, 1954), also allows an infinitely open field of search for confirmations.

Likewise in physics, the law of conservation of energy can never be falsified because of the possible existence of unknown forms of energy that would confirm it. The law began in the form that the sum of the kinetic and potential energy is constant. Then heat energy had to be included, and various other additions, such as electrical energy, had to be made to preserve the constancy. Whenever energy seems to be lost, it is possible that it will be found in a new form. This possibility leaves the field of confirmation infinitely open, and hence the law is irrefutable.

The first comment to be made is that a specific form of the law is refutable, and several have been refuted. When one is refuted it is replaced by a new form. All that survives is the unspecified form.

It is hard to conceive what a situation would be like in which energy was lost in some process and not transformed in some new guise. But, so long as it is not found, a research physicist has to decide whether or not to go on looking for a new form, and if there should be no new form he has no means of finding out, however long he may keep on with unsuccessful attempts, that there is none. This shows that the unspecific form of the law could be confirmed, if a new form happened to be discovered, but could never be known definitely to be false. Thus the unspecific form of the law is irrefutable. When a principle, or something resembling a refutable hypothesis, has this character, it has, as I have previously put it (Wisdom, 1956, p. 26), a largely programmatic function—whatever other function it may also have—it prescribes a programme of research. Thus the unspecific principle of conservation of energy, if a specific form is refuted, tells you to look for a new form. But it goes farther, for it prescribes limits to the kinds of theory you should try to construct: thus it has the function as Watkins (1957) had put it, of a regulative principle, which governs not phenomena but theories, or constitutes a framework that theories must fit.

If a framework is not refutable, can it be given up only because of weariness, disillusionment, or failure, or can it be given up on rational grounds? I will propose a refutability theorem that would enable this to be done.

I will use yet another example. A longstanding assumption in physics was that 'Energy occurs in all possible quantities (or is continuous)'; this is clearly infinitely open to confirmation in the same way as before, and is irrefutable. Now Planck discovered phenomena of radiation which he interpreted as due to discontinuous processes (quanta of action). It would be difficult to interpret the phenomena otherwise, but in principle it was possible that this could be done if ever other quantities of action should be found that would restore continuity.

However, Schrödinger's discovery of the wave-equation constituted a theory with discontinuities as consequences. This theory was independently testable (i.e. testable otherwise than by means of quanta of action), tested, and confirmed (e.g. by the spectrum of the hydrogen atom). Now it is a deductive consequence of the wave-equation that energy levels are discontinuous. Hence Schrödinger's theory refutes the assumption that energy is continuous.

Similarly a theory with perpetual motion as a consequence would, if tested and confirmed, refute the unspecific law of conservation of energy.

It is vital to note that when the above examples were said to be irrefutable, this meant that no fact or observation could refute

them,* but that they may be refuted in a different way, namely, by an independently tested and confirmed theory. Thus a framework, which governs not phenomena but theories, may be refuted by theories.

It should be added that this kind of refutation is hypothetical in a way that refutation by observation is not, for the refuting theory, though tested and confirmed, may later be falsified; then the programme it had refuted becomes 'derefuted', and reverts to its original position of being infinitely open to confirmation but never to refutation by further search for appropriate facts.

So long as a tested theory is not refuted, one has no option until it is seriously challenged but to accept its observational consequences (e.g. the prediction of eclipses) and its consequential empirical generalizations (e.g. the harmonic motion of a pendulum): no sensible or rational person would try to build a simple clock and deliberately act against the law of harmonic motion. One has to accept equally any other sort of consequence of such a theory, and therefore to reject any observationally irrefutable law that it refutes.†

* What was basically referred to in the context of refutability of empirical hypothesis was refutability by observation; Popper is indeed concerned with refutability by any method, but the core of his fundamental contribution to the theory of what constitutes science lies in refutability by observation.

† Watkins (1958, p. 345) and Bartley (1962) have been concerned with the clash between a regulative principle and a testable empirical theory. Watkins was mainly concerned in the context with the opposition to an empirical theory by a regulative principle (and with the position of a regulative principle that follows from an empirical theory); I am concerned with the converse, i.e. an empirical theory opposing a regulative principle. Bartley touched on this: he recognized the direction of this opposition; but he was concerned with *disproof* and rightly noted that a regulative principle cannot be *disproved* by an empirical theory, and thus did not extract the idea of refutation in the sense I have put forward.

It would seem that a major breakthrough in science is brought about, not by the refutation of a theory at the hands of an observation or the replacement of the theory by another one, important though this is, but by the refutation of a framework at the hands of a theory and its replacement by the framework of that theory.

Such refutability has, further, a significant bearing on what is to be considered as rational. The examples given of observationally irrefutable laws in physiology and psychology exercise strong pressure to regard a purely psychological theory and the theory of psychosomatic medicine as unscientific and irrational, because they are incompatible with the laws mentioned which form part of reputable branches of science and which derive prestige from being irrefutable.

To summarize the thesis: A law that can be confirmed without risk of failure, because what is sought to confirm it may sometimes be found but never be known to be non-existent, is 'irrefutable' in the sense that there is no observation that can refute it; if a theory is discovered that is testable without assuming the falsity of the law, actually tested, and confirmed; then the law is (hypothetically) refuted by the theory.‡

It seems to me that the pleasure-principle is like the conservation-principle. If you give it a specific form, say to do with sensuous pleasure, you find that it is false and that you have to add new types of pleasurable satisfactions to give the principle a form that will work. Thus specific forms of the principle are refutable, and several are easily refuted. (When made sufficiently wide to include satisfactions from great self-sacrifice, the principle becomes almost vacuous, though perhaps not entirely so.) The unspecific principle is, like that of conservation, irrefutable by searching for phenomena to contradict it, but it might be refuted by a new theory. It would be refuted, for example, by Freud's (1922) theory, which

‡ The preceding part of this section, apart from the first paragraph, is reprinted by permission from *The British Journal for the Philosophy of Science*, 1963, 11.

goes beyond the pleasure-principle, that the organism has to master stimuli for purposes of self-preservation irrespective of whether pain is reduced. And it would be refuted, if it were a consequence of Fairbairn's theory of the universality of object-relationships, that an ego must in certain circumstances choose from a set of objects the one that will not give the highest total of satisfactions.

It is just possible that this is so. For there are persons who give a strong impression of desperately seeking object-relationships and equally desperately seeking a bad object. Now this might be construed, along classical lines, as yielding masochistic satisfaction, though it requires to be confirmed that such situations do in fact yield a satisfaction; but it might be that a good object, while giving numerous satisfactions, was hardly felt to be an object at all, so that the only object that could be accepted really as an object would be a bad one, and therefore chosen in preference to one that would in fact provide satisfactions.

As a corollary, if this were so, we should be in a position to solve the problem of the compulsion to repeat: it would mean seeking a relationship with an enemy no matter what it cost.

(iv) *Theories of the schizoid position and three egos*

According to Fairbairn, the infant's first objects are neither good nor bad; such discrimination arises only after the first experience of frustration (it therefore cannot be long delayed after birth). Further, as a result of the first frustration, the first introject is formed, and it is of a bad object.

Without going into questions of physiological maturation of cortical functioning and of what kinds of experiences may or may not be possible to the infant, we should none the less note that Fairbairn makes important presuppositions: (*a*) that the infant perceives (or has some cognizance of) an object *as an object*, which means at least something possessing certain properties such as satisfaction-giving or frustration-provoking; (*b*) that the infant ascribes a more specific property to a frustrating object, namely, that it is rejecting (e.g. he feels not simply hungry but unwanted); and (*c*) that the infant attaches a value, i.e. the value bad, to a rejecting object. These are large assumptions to make about a near to new-born baby—not that this is necessarily against them, for there can be little doubt that the capacity commonly ascribed to children in the first few years is grossly underestimated, but if we make a large assumption it is prudent to be alive to the fact. Fairbairn seems to take no cognizance of it—at any rate he offers no discussion of the numerous alternative possibilities. He does briefly indicate that his view differs from Melanie Klein's, but his point seems to be that his theory, postulating the pre-ambivalent object, obviates the assumption of a death-instinct; if this is his point, he must suppose that her theory, postulating good and bad objects from the beginning of life, requires this assumption; but this could not be a necessary presupposition, for no explanatory idea can be a necessary presupposition.

It is well that Fairbairn has brought this important problem forward. This part of his theory, however, contains too little warp and weft to admit of any brief discussion; to make a serious point would require prolonged discussion; from this question I will therefore disengage, though I hope to tackle it on another occasion.

We can, however, draw a general contrast between Fairbairn's theory of the schizoid position and Melanie Klein's theory of the paranoid-schizoid position.

It was pointed out earlier on that Fairbairn's theory has less content than Melanie Klein's, and that the difference lies in the additional factors in her theory of projection and persecution; but the cautionary addendum was made that the deficit, if such there is, might be balanced by the theory of the ego. This is true, I think, to a considerable extent. Strain arises, for Fairbairn, from the action of the anti-libidinal ego against the libidinal ego. But the antilibidinal ego is not an orbital, like Freud's

superego generally is, or like Melanie Klein's persecuting bad introjected object. And the antilibidinal ego owns its aggression as its birthright; hence aggression does not have to be projected on to an orbital to boomerang as persecution. Thus the work required of projected aggression is done by the antilibidinal ego without projection. Hence Fairbairn's theory of the schizoid position largely does the same work as Melanie Klein's theory of the paranoid-schizoid position.

But it does not seem to do exactly as much work. In all cases of some paranoid type there is persecution by an orbital, as Fairbairn would agree. Now how would such a pathology arise unless there was a precursor model for it, i.e. unless the infant's mind contained projection and persecution in its structure?

It would therefore seem that, so far as it is different from Fairbairn's theory, Melanie Klein's is needed to do justice to the pathology of paranoid types. On the other hand Fairbairn's theory contains a contribution, which is not explicit in Melanie Klein's account of ego splitting, concerning strain between the libidinal ego and the antilibidinal ego.

Ideas corresponding to libidinal ego and antilibidinal ego, whether called that or not, may well prove indispensable for the further elaboration of psycho-analytic theory. Indeed, working from a different angle, I have virtually used such ideas, and could not avoid doing so, when I introduced a hypothesis of 'nuclear strain' in attempting to elaborate the Kleinian theory of the depressive position (where I dealt with destructive attitudes towards an object, split off from other attitudes, in a nuclear context, which gives them ego character). It seems to me that Fairbairn's idea of a central ego is necessary, for instance, for effecting a differential union, however tentatively, of good and bad parts of the ego as required by the paranoid-schizoid position, and this if harmonious can permit further union. Further I know of no one except Fairbairn who has drawn explicit attention to the need for a section of ego that observes and communicates with the other sections.

I do not find Fairbairn's terminology particularly apt, however; and, though such matters are of secondary importance, I should prefer the name 'communication centre'.

Fairbairn's term 'antilibidinal ego' would seem to condense or slur over a process of basic importance. The natural hypothesis to make is of a destructive ego, which in certain circumstances becomes antilibidinal—at any rate Fairbairn gives no firm reason for regarding the antilibidinal factor as irreducible to anything further.*

Further, to speak of three egos is not very happy: it suggests that every ordinary person is going about with three simultaneous personalities, and this is not what is meant. I suggest the terms 'libidinal lobe' and 'destructive lobe' of the ego. These with the 'communication centre' would seem to be essential components of the ego, or rather of what I have called the nucleus of the self.

CONCLUSION

Fairbairn's theoretical work has not, I think, been adequately acknowledged, recognized, or studied. The stimulus value of it is very considerable; he has raised questions and challenged existing hypotheses overtly and incisively; and he has introduced new ideas of value. The stimulus value consists at least in part in focusing attention on issues of importance that can easily be overlooked. His most significant challenges are to the id-libido theory, the pleasure-principle, the zone hypothesis. His most significant contributions concern the dominant role of schizoid mechanisms, the re-orientation produced by the primacy of object-relationships, and the ingredients of the ego. Subject to slight qualifications, all these contributions seem to me to be likely to prove permanent elements in psycho-analytic theory.

* Fairbairn changed his terminology from 'internal saboteur' to 'antilibidinal ego', but both terms seem to refer to destructiveness that is inherently antilibidinal.

Less effective are his challenge to the idea of the primacy of aggression (he may be right, but the challenge does not show this), his view of the nature of the first objects in infantile experience and what the infant does with them, his elaboration of schizoid processes, and the absolute independence of impersonal roots that he credits to the ego—for, even without going to these lengths, one could go the whole way in granting the primacy of object-relationships. Moreover, for one who has tried to go to rock-bottom, it is surprising that Fairbairn has not investigated the relation between two split-off pieces of ego, for though split they are not so isolated that there is no sense of splitness and therefore of belonging-ness (admittedly everyone else has overlooked this too), that he has not attempted a more elaborate psychology of early mental processes, and most of all that he has nothing to offer to explain how the position of pathological splitting can be overcome as well as what constitutes the difference between pathological and normal splitting.

In a field where few make contributions and hardly any do so on Fairbairn's level, it may seem ungrateful to complain about what he has not done or attempted. There are several reasons, however. If he had done less fine work, one might have had no expectations; but Fairbairn's contributions arouse one's expectations and he stops work too soon. Further, with his intellect, imagination, and clinical experience he might be prevailed upon to accept the challenges I have made (assuming he agrees that I have not misconstrued his views and that there is no obvious answer to my criticisms). But chiefly because my criticisms are intended to raise or at least underline some fundamental problems.

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Psychodynamic theory and the problem of psychotherapy*

By H. GUNTRIP†

The title of this paper may well appear pretentiously large in scope. It is best, therefore, to make it clear at the outset that I mean simply to convey the notion of tracing developments in psychodynamic theory to see how they bear on the only partially solved problem of psychotherapy. This became a particular interest of mine from about 1950 as my clinical concern came to centre specially in the study of schizoid problems. The results of this work began to emerge by 1960, and throughout I had found Fairbairn's formulations in the field of theory invaluable. Two concepts, the *Ego* and the *Schizoid Process*, came to dominate the enquiry. They at once suggest a contrast to a psychodynamic theory based on the very different concepts of *Instincts* and *Depression*, as in the classic Freudian theory. Nevertheless, the fact that in the 1920's Freud himself turned his interest from instincts to the analysis of the ego, shows that what we have to consider is not two opposed views, but a development which has been going on in psychodynamic research for some forty years. For this development Freud himself provided the initial impetus and it arose logically out of his own earlier work.

It may be well at this point to pause and reflect on the nature and place of theory in our work. All are agreed that we do not interpret to patients in theoretical terms, nor do we seek to fit the patient into a pre-determined theoretical scheme. Were we to do so, we would learn nothing new from our clinical work.

This error in technique is, probably, not in fact always avoided. We must use our theoretical concepts to guide our thinking in trying to understand the patient, and therapists obviously do not find it easy to let what the patient presents modify the concepts they are used to and have acquired a vested emotional interest in. Nevertheless, human problems are still so far from solution that we cannot afford to become theoretically static. *Concepts* are most useful at the stage at which they are being formed. They represent the intellectual effort to clarify and formulate new insights which are emerging in the thick of the pressure of clinical work. For a time they act as signposts pointing the way in the right direction for the next advance: but concepts date. By the time further new experience has begun to gather, previous concepts have become stereotyped and too rigid, and they then act as a barrier to fresh thinking. This has been the fate of some of Freud's concepts, in particular those of instinct, libido, aggression (as an innate drive), the id, the super-ego, the Oedipus Complex. It is now becoming clear that they mark stages in an advancing psychodynamic enquiry. Freud opened the way to still deeper levels where new insights and new concepts are called for. To try to work on new material with nothing but the old conceptual tools retards deeper understanding.

Psychoanalysis has been carried, as Freud himself was, by clinical pressures to ever deeper levels of psychic life, so that it may be said in general that we have no choice now but to focus our thinking more on the problems of ego development in the first year than on the Oedipal problems of later infancy. Mrs Klein's attempt to read back the three-person Oedipal problems, dated at 3–4 years in the classic theory, into the first-year two-person problems, was not generally accepted, but was eloquent

proof that a change in basic theoretical stand-point was developing. The process of change has been at work ever since Freud turned definitely to ego analysis in the 1920's, but of all the analysts who have contributed to the slow furthering of this change, so far only one, Fairbairn, has made a specific attempt to think out the nature of the fundamental re-orientation of theory that is going on. He would be the last person to wish that his contri-bution to theory should, in turn, become a fixed and stereotyped scheme blocking the way to further insight. Nevertheless, he has formu-lated certain basic concepts which appear to be as necessary for the intelligible ordering of our field of knowledge at this stage, as were Freud's Oedipal concepts and his structural terms at earlier stages. Fairbairn's work is no more a mere proposed change in termino-logy, as some critics suggest, than was Freud's.

I hold no particular brief for any conceptual terminology as final. Terms are only useful tools to be discarded when we find better ones. No doubt in fifty years time wholesale revision will have taken place. The term 'libidinal', though useful, is far from satisfactory as standing for the fundamental life-drive in the human being to become a 'person'. Its historical associations are too narrowing for it to be adequate to this new orientation that we have now to take into account. If the term 'libidinal' is revised, all Fairbairn's terms will have to be revised. Meanwhile, till someone suggests a better term than 'libidinal', I feel compelled to say that, once mastered, I have found Fairbairn's terminology closer to clinical realities than any other, and too valu-able not to be used. Balint writes: 'How much unconscious gratification lies hidden behind the undisturbed use of accustomed ways of thinking...is best shown by the often quite irrational resistance that almost every analyst puts up at the suggestion that he might learn to use or even only to understand a frame of reference considerably different from his own' (1952, p. 232). I shall seek in what follows to place Fairbairn's work in what seems to me to be its proper position and context in the march of psychodynamic theory, to show in what way I found it invaluable in my own particular study of schizoid problems, and to present it as a challenge to willingness to think, where necessary, in new terms as new insights develop. At the International Congress of Psychoanalysis in Edinburgh in 1961, one speaker objected to Winnicott asking us to use 'new terms such as "impingement", etc.'. But the time seems to have come when progress will be blocked if we persist in trying to pour supplies of new wine into old bottles that are too small.

My own interest in this whole matter was aroused when, around 1950, three patients, each in their own way presented the same problem.

(1) The first was a middle-aged, unmarried engineer running his own business; well educated, who sought analysis of his own accord for attacks of guilt-burdened depres-sion. He had some six years of orthodox analysis whose content would be familiar to every analyst. He talked out his early loveless family life, his submissiveness to his egotistical mother and fear and hate of his violent father, sibling jealousies and adolescent rebellion. He produced Oedipal and Castration dreams, sado-masochistic fantasies, genital, anal and oral; guilt and punishment reactions. A classic psychoanalytic text-book could be written out of his material. Throughout he remained a conscientious hard-working obsessional per-sonality, with all his emotions under tre-mendous internal control. His personality type did not change but he improved greatly as compared with his original crippling depres-sions. His ego defences, we may say, were modified and he felt more free to work. He summed up his position thus: 'I'm very much better. I feel I've cleared all the outlying areas of my neurosis, but I feel I've come up against a circular wall with no doors or windows and too high to see over. I go round and round it and have no idea what is inside. I know there's something I'm doing that blocks further analysis and I don't know what it is. It's diffi-cult to let anything more out. I've got to keep

fit to run my business.' Here, apparently, was *a closely guarded hurt and hidden part of his inner self into which neither I, nor even his own conscious self, was allowed to intrude.* He once dreamed of going down into an underground passage and coming to a halt at a locked door marked 'hidden treasure'.

(2) The second patient, an older, very ill professional woman whose doctor said she would never work again, had a similar background and normal Oedipal analysis during which she returned to work, suffered no further breakdown, and was able to work till she qualified for a full pension. She then seemed to stick, and like the first patient held her gains but made no further progress. At that point she dreamed of walking along a road and coming up against a huge wall. There was no way of getting forward and she did not know what lay on the other side. Her comment was 'I've got to go on, if you can stand it'. She clearly felt that if she succeeded it would mean a difficult time for both of us. Here again was *this clear-cut unconscious knowledge of an inaccessible cut-off part of the inner personal life into which the patient seemed unable and afraid to penetrate,* but which had to be opened up to reach a real 'cure'.

(3) The third patient, a medical man in middle life, presented the same theme in a different way. This was the case with which I opened my 1961 paper on 'The schizoid problem and regression'. His presenting symptom, an embarrassing and active preoccupation with breasts, faded out under analysis only to be replaced by powerful phantasies of retirement from active living into some impregnable stronghold isolated from the outer world. Like the other patients he carried on his active professional life. This then must have indicated *the drastic withdrawal from the outer world of a specialized part of his personality existing passively inside the fortress, the impassable wall.* These patients were markedly schizoid, detached, shut in, had great difficulty in human relationships, and would feel alone and out of touch in a group.

At this point I tried to write a paper on 'The Schizoid Citadel' but could not arrive at any satisfying conclusion. Therefore, as a starting point for enquiry, I made a clinical study of 'Fairbairn's theory of schizoid reactions' (Guntrip, 1952) and set out, first, to gather fresh clinical material on schizoid problems, and secondly, to survey the development of psychodynamic theory from Freud to the American 'Culture Pattern' writers, and to Mrs Klein and Fairbairn, to see what pointers were emerging to the solution of this problem. The result of this historical study I presented in the book *Personality Structure and Human Interaction* (1961 a). On the clinical side, I owe everything to a group of schizoid patients whose variety was fascinating: a biologist, a communist, a hospital sister, a university lecturer, a grandmother in her fifties, a young borderline schizophrenic wife, a social worker who had had a paranoid schizophrenic breakdown, a young middle-aged mother who was also a language teacher, an outstandingly successful but most unhappy business man, and so on. Their treatment always seemed to move ultimately beyond the range of the classic psychoanalytical phenomena, the conflicts over sex, aggression, guilt and depression. All patients began by producing this kind of material, which occupied analysis in the first few years. For what came after that I did not find much help, except in the interpretation of details, in the literature on schizoid problems. It seemed to lack intrinsic connexion with the existing psychoanalytical theory of Oedipal and depressive problems. I had to let impressions accumulate, and only in the last three years have these begun, as I feel, to disclose some definite pattern.

One strongly emerging theoretical trend provided the necessary standing-ground for thinking. In 1949 Balint called for a transition from a physiological and biological bias to an object-relations bias in theory (1952). That was exactly the major trend that stood out in the historical survey. It was visible in the work of Americans such as Horney, Fromm and Sullivan, though more from the social and

'culture-pattern' point of view. As early as 1942–44 Fairbairn made a fundamental revision of theory on exactly the lines Balint called for, from the endopsychic rather than the cultural viewpoint (1952). Here and elsewhere were the signs of a growing and widespread consensus of thought which can be expressed in several different but parallel and related ways. Theory has been moving from concentration on the parts to attention to the whole, from the biological to the properly psychological, from instinct vicissitudes to ego development, from instinct gratification to ego maintenance, and from the depressive level of impulse management to the deeper schizoid level where the foundations of a *whole* personality are, or are not, laid. Throughout, the concepts of *the Ego* and *the Schizoid Process* became ever more dominant.

Classic psychoanalytical theory is a moral psychology of the struggle to direct and control innate antisocial but discrete and separate instinctive drives of sex and aggression, by means of guilt. This, when it produces too drastic repression instead of 'sublimation', leads to the mental paralysis of internalized aggression, self-punishment and depression. When Freud turned to ego analysis, however, he started lines of enquiry which were destined to lead to a quite different orientation; for schizoid problems turn out to be, not problems of the gratification or control of instincts, but problems of ego splitting and the struggle to recover and preserve a whole adequate ego or self with which to face life. This newer type of theory had much to say about the problems of my patients who were unconsciously guarding their secret schizoid citadel in which some vital part of their total self apparently lay buried, hidden and lost to use. Impulse psychology had little enlightenment to offer on this.

Here I must record my agreement with Fairbairn that the term 'psychobiological' is an illegitimate hybrid which confuses two different disciplines. It is like that earlier hybrid 'physiological psychology' as set forth in McDougall's book (1905). It was just

physiology and not psychology at all. We study the one whole of the human being on different levels of abstraction for scientific purposes. Biology is one level, psychology is another. Each deals with phenomena, organic or psychic, which the other cannot handle. When it comes to *therapy*, knowledge from *all* disciplines must be taken into account. We do not suppose ourselves to be dealing with two separate entities, one called body and the other mind, but neither can we study such a complex whole as if it were a kind of Irish stew in which everything is lumped together in one pot. We must abstract its main distinguishable aspects and stick consistently to what we select to study.

The business of psychodynamic research is with that aspect of the whole man which we call the motivated and meaningful life of the growing 'person' and his difficulties and developments in object relationships with other persons. A dynamic psychology of the 'person' is not an instinct theory but an ego theory in which instincts are not entities *per se* but functions of the ego. The way an instinctive capacity operates is an expression of the state of the ego. The trend of psychoanalytic theory moves steadily in that direction. Instinct theory *per se* becomes more and more useless in clinical work, and ego theory more and more relevant. Outside the sphere of pure psychodynamics, I would think that the philosopher J. MacMurray has given the *coup de grâce* to instinct theory in the study of human persons, in his *Gifford Lectures*, Vol. 2, 'Persons in relation'. The most important single subject of investigation on all sides is the earliest stages of ego growth, as in the work of the Kleinians, Fairbairn, Winnicott, and researches into the psychodynamics of schizophrenia. The classical Oedipal, social, sexual and aggressive conflicts are dropping into their place as aspects of the internal, sado-masochistic, self-exhausting struggle of *an already divided self* to maintain psychic defences against ego collapse.

I have thus come to feel that the first great task which confronted Freud in his pioneer exploration was that of analysing the area of

moral and pseudo-moral conflict. This had hitherto comprised man's whole traditional account of his nature and troubles; and it blocked the way to more radical understanding. Freud did analyse it so exhaustively that he opened the way to the deeper level hidden beneath it. The result of Freud's work is that unrealistic traditional ideas about children have been replaced by an ever deeper knowledge of the very earliest infantile fears and ego weakness. Freud actually took over the traditional popular and philosophical psychology of Plato and St Paul as his starting point. St Paul was content with a dualism of the 'law of the mind' and the 'law of the members' in inevitable warfare. Plato gave us the trichotomy which the Western world has accepted right up to Freud and the present day. Human nature comprised a lustful beast, a spirited lion and a rational man, the id, the super-ego and the ego. Plato's many-headed beast of the lusts and passions of the flesh and St Paul's 'law of the members' became the powerful anti-social instincts of sex and aggression in the id. Plato's charioteer of reason and St Paul's 'law of the mind' became the controlling ego with its scientific reason. Just as Plato's 'reason' made an ally of the lion, the fighting principle, turning it against the beast to enforce control, so Freud envisaged the ego working with the sadistic super-ego to turn aggression inwards against the self, and showed how pathological guilt produced depression.

Freud used the traditional philosophical moral psychology of impulse control, but he used it in a wholly new way, to guide an original and factual clinical analysis of the detailed mental processes involved in man's experience of moral and pseudo-moral conflict. All this was analysed so exhaustively that it represents a reasonably completed scientific investigation of man's sado-masochistic struggle to civilize the recalcitrant impulse-life he finds within himself. Yet Freud failed to answer or even to ask the crucial question. Since man is without doubt social by nature, how does it come about that

he feels such anti-social impulses so often? Why do men have anti-social impulses? Freud, like all his predecessors, simply assumed that they were innate, that in man's nature there was an unresolvable contradiction of good and evil. This is the traditional view of man in our culture.

However, Freud's analysis of moral conflict unwittingly revealed the fact that this is not the whole of, nor even the deepest element in, the psychic experience of human beings. In fact, man's age-old conviction that all his troubles come from his possession of mighty if nearly uncivilizable instincts of his animal nature, turns out to be our greatest rationalization and self-deception. We have preferred to boost our egos by the belief that even if we are *bad*, we are at any rate *strong* in the possession of 'mighty instincts'. Men have not wanted to see the truth that we distort our instincts into anti-social drives in our struggle to suppress the fact that deep within our make-up we are tied to a weak, fear-ridden infantile ego that we never completely outgrow. Thus Fairbairn regarded 'infantile dependence', not the 'Oedipus Complex' as the cause of neurosis. The Oedipus Complex is a problem of 'instincts'. Infantile dependence is a problem of 'ego weakness'. Depression is the psychology of badness. The schizoid problem opens up the psychology of our fundamental weakness, and human beings would rather be bad than weak. This shift in the centre of gravity in psychodynamic theory will enforce a radical reassessment of all philosophical, moral, educational and religious views of human nature.

Psychoanalytic practice seems to be in advance of psychoanalytic theory in this matter. In my paper on 'The manic-depressive problem in the light of the schizoid process' (1962) I traced how, in the 1960 'Symposium on depression' in the *Int. Journal*, the papers oscillated between two opposite poles of this complex illness. Viewed as *classic depression* it was explained by reference to ambivalent object relations and guilt over sexual and aggressive drives. Yet there appeared to be another aspect of it characterized as *regression*,

which needed to be explained rather by ego splitting, arrested ego development, weakness, lack of self-fulfilment, and apathy. But depression and regression were not clearly related, though Zetzel remarked that in the modern view of depression the significant new concept was that of the 'ego'. It is, however, hopeless to deal with ego psychology in terms of instinct theory. The problems of ego psychology are those of loss of unity and ego weakness, depersonalization, the sense of unreality, lack of a proper sense of personal identity, of the terror some patients experience of feeling so 'far away' and 'shut in' that they feel they'll never get back in touch again. These phenomena can only be dealt with by a theory based firmly on the analysis of the schizoid processes of withdrawal to the inner world under the impact of primary fears. It is in this region that the uncertain beginnings of ego development are to be found.

So far only Fairbairn has sought systematically to re-orientate theory from a depressive to a schizoid foundation. Nevertheless, the whole drift of psychoanalysis today is in that direction. In a recent private communication Fairbairn stated that the internal situation described in terms of object splitting and ego splitting 'represents a basic schizoid position which is more fundamental than the depressive position described by Melanie Klein....A theory of the personality conceived in terms of object-relations is in contrast to one conceived in terms of instincts and their vicissitudes.' Freud's structural terms, id, superego, ego, give an account of classic depression and moral conflict. Fairbairn's structural terms, libidinal ego, antilibidinal ego, central ego, give an account of the schizoid process and the loss of the primary unity of the self.

As I see it there have been four stages in the development of psychoanalytic theory. (1) *Freud's original instinct theory* which enabled a penetrating analysis of moral and pseudo-moral conflict to be made. This led to (2) *Freud's ego analysis*. Because this remained tied to instinct theory, it could not give more than a superficial account of the ego, as a utilitarian apparatus of impulse control, an instrument of adaptation to external reality, a means of perceptual consciousness, etc. Before an adequate theory of *the ego as a real personal self* could be worked out, a third stage had to come about. (3) *Mrs Klein had to explore the psychology of the object as psychically internalized to become a factor in ego development*. She explored the psychology of internal object relations as thoroughly as Freud had explored that of impulse management. Mrs Klein's work is 'an object-relations theory with emphasis on the object' and it led to a fourth stage, (4) *Fairbairn's 'object-relations theory with emphasis on the ego'*. Fairbairn's primary interest had always been in the ego, as seen in an early paper on a patient's dream-personifications of herself. But he made no progress with this till Mrs Klein's work made its impact on him, as he is the first to acknowledge. Now, his work brings out clearly that the importance of the object is not primarily that of being a 'means of instinctual gratification'; this gives only a psychology of instinct vicissitudes. The importance of the object lies in the fact that it is 'a necessity for ego development'; this gives us a psychology of ego vicissitudes, ego differentiations, splittings and what not. He brought Mrs Klein's 'object-relations theory' back full circle to ego theory again, but this time not to Freud's superficial ego theory, but to *a fundamental ego theory which makes psychodynamics a genuine theory of a real self or person, a unique centre of meaningful experience growing in the medium of personal relationships*. Fairbairn is, of course, far from being the only analyst to see the need to orientate theory and therapy afresh to the true selfhood of the whole person. Winnicott writes that the goal of therapy is: 'the shift of the operational centre from the false self to the true self....That which proceeds from the true self feels real' (p. 292, 1958). Again: 'In favourable cases there follows at last a new sense of self in the patient and a sense of the progress that means true growth' (pp. 289–90). Winnicott's theory of the true and false self is likewise a theory of ego

splitting and deals with phenomena that Freud's structural terms take no account of. Fairbairn, however, is the only analyst who has taken up the task of the *overall* revision of theory from this point of view. The result is an impressive intellectual achievement.

In the communication quoted Fairbairn regards separation anxiety as the earliest and original anxiety, and as the basic cause of the schizoid process of flight or withdrawal of part of the now split ego from contact with the outer world. There are several causes of separation anxiety. Fairbairn earlier stressed that unsatisfied love needs become dangerous and the infant draws back. Winnicott stresses the infant's direct fear of the 'impingement' of a bad object, and the infant finding himself simply deserted, neglected. However caused, the danger of separation is that the infant, starting life with a primitive and quite undeveloped ego, just cannot stand the loss of his object. He cannot retain his primitive wholeness and develop a sense of identity and selfhood without an object relation. *Separation anxiety then is a pointer to the last and worst fear, fear of loss of the ego itself, of depersonalization and the sense of unreality.* The reason why patients hold on with such tenacity to their Kleinian inner world of internal bad objects, and their Freudian inner world of Oedipal conflicts over sex and aggression, is that they have so weakened their *external* object relations by early schizoid withdrawal inside, that they are compelled to maintain a world of internal phantasied objects to keep their ego in being at all.

It seems to me that conflicts over sex, aggression and guilt are, in the last analysis, used as defences against depersonalization, and the patient is reluctant to give them up. Patients will try to go back to these classic conflicts unless we keep them well analysed, rather than face the terrors of realizing how small, weak and radically cut off, shut in and unreal they feel at bottom. A dream of a male patient of fifty illustrates this. 'I was engaged with someone (undoubtedly his tyrannical father) in a tremendous fight for life. I defended myself so vigorously that he suddenly stopped fighting altogether. I then immediately felt let down, disappointed and quite at a loss, and thought "Oh! I didn't bargain for this".' His real life was conducted very much in terms of rationalized aggression, opposing authority, attacking abuses, defending his independence, all really in the interests of keeping his insecure ego in being. He couldn't keep going without the help of a fight. Another patient said: 'If I don't get angry with my employees, I'm too timid to face them. I feel some energy when I'm angry, otherwise I feel just a nobody.' *That is the basic problem in psychopathology, the schizoid problem of feeling a nobody, of never having grown an adequate feeling of a real self.* If we go far enough it always emerges in some degree from behind the classic conflicts. I suspect this to be more true of all human beings than we like to know, and that the chronic aggression which seems to be the hallmark of 'man' is but a veneer over basic ego weakness.

PSYCHOTHERAPY

When we turn from theory to consider its bearings on therapy, this conclusion hardly makes the task of psychotherapy look any easier. In my group of patients I began to observe the emergence of a fairly consistent pattern of three stages of treatment, which we may call the stages of (1) Oedipal Conflict, (2) Schizoid Compromise and (3) Regression and Regrowth.

(1) *In the first stage*, whatever diagnostic label might be stuck on the patient, hysteric, obsessional, anxiety state, etc., the first few years of analysis dealt with the problems of the child struggling to adapt and maintain himself in an unhelpful family situation widening out into the social environment. This is broadly the 'Classic Oedipal analysis' of defences and conflicts concerning ambivalent object relations of love and hate, primarily with parents and then transferred into wider areas of living. As symptoms faded, the underlying conflicts over sex, aggression and guilt would emerge

and classic depression have to be dealt with. Such analysis would lead to marked improvements which were very welcome, yet left the feeling of something else unspecified still to be dealt with. The analysis produced valuable but not final results just because it dealt with defences, not causes. Thus ten years ago a man came to me very depressed after the death of his father. He said 'I can afford time and money for 100 sessions'. I advised him to spread them over two years since growth is a matter of time. In addition to his depression, he was in a rut in his work and his childless marriage was hardly happy. At the end of his 100 sessions he was definitely improved. He had got out of his rut at work, taken a better job and was doing well. He and his wife had faced their problem and adopted a child. I heard from him recently that he was carrying on well. I had told him that his whole problem could not be cleared up in 100 sessions and he accepted that. He said he still had occasional moods but felt he understood and could manage them, and his work and home life were satisfactory. That is a worthwhile result if not a complete one. In practice, the greater part, certainly of short-term psychotherapy, is on this level. In the early days of psychoanalysis a year was adequate for treatment. Fairbairn once said to me: 'The more we analyse the ego, the longer analyses become.' I found that the initial Oedipal analysis usually led on to:

(2) *A second stage* of marking time on the ground gained, retaining improvements by effecting a more rational control, i.e. a modified and more reasonable obsessional or schizoid character. If maintained, this may well represent, for all practical purposes, a cure: in fact it is itself a schizoid compromise in varying degrees. The patient does not do without personal relations, yet cannot wholly do with them, or cannot stand their being too close and involving. He takes up a 'half in and half out' position in which he hopes to remain relatively undisturbed. Like the patient cited, he may leave analysis and with luck remain stable. There is no doubt that such relative stabilization is possible, and can and does work in a number of cases. If a patient *can* stabilize to that extent without going deeper, it is not good to probe deeper. Nevertheless, not all analyses can terminate at that stage. The patient may leave and later encounter too severe real-life stresses which break him down again and bring him back to treatment. Or he may stick at analysis without really making use of it, seeking to make analysis itself his compromise solution, gaining some support from sessions but not changing much. This may break down; the patient feels frustrated, leaves in a resentful mood, and finds that his resentment of the now absent analyst is quite a useful if hardly constructive motivation helping to keep his ego functioning. Lastly, the patient may stick at analysis and allow his compromises to be analysed till slowly he gets beneath them. Whether he has returned to analysis with a second breakdown or carried on doggedly till the deepest levels were reached, the result is much the same.

The way in which the schizoid compromise solution is attempted and is liable to break down is best illustrated by two actual cases. A male patient in the early fifties, who had decided to end a long analysis and move to another city to start life afresh said 'The height of my ambition now is to get through life without trouble. It's not that bad an aim, a bit negative; it has a certain vegetable feel about it, a kind of blankness. Under such circumstances you don't feel anything much at all. That's a preferable state to feeling awful. Big changes have gone on in me really. It's a tremendous relief not to feel so frightened, nor so excited in a bad way. Yet it feels also like losing something.' The last remark showed that he was aware that this was not a final, positive result, but a compromise solution aiming at maintaining improvements. It lacked the vital sense of reality in living.

How a well-established compromise solution can break down is seen in the case of a woman of 48 years. She had recovered complete physical health after a long analysis, and at a late age took a university course to qualify

for a profession, established her independence of parents, got a flat and a car of her own and made all the progress it was possible to make along those lines. The fact that this welcome improvement and independence also included a schizoid compromise, protecting her from any real involvement in personal relations, became clear when she suddenly panicked at the prospect of marriage. In one session she said: 'I think I'll be best keeping my freedom and independence; my job and money, flat and car, and not feeling too deeply about anything. I don't want to feel love or hate. If I feel I become a baby. If I skate over the surface and don't feel much, I can be more grown up, and in a way I enjoy life better then, especially driving my car. Really I'm a child and don't want to do anything, I only want to go home to mother and father. I picture our family living on a desert island and never going out of it. I can't really face life. I never wanted to do a job, only stay at home and do housework with mother. But I know they can't live for ever and I've got to think out a different way of life. Perhaps really I'll drift into marriage, though with my eyes open, and make something of it.' The challenge of marriage, however, made it increasingly difficult for her to maintain her improvement based on schizoid compromise, and she was pushed beyond it.

(3) *The third stage.* Here problems are now quite different, specifically schizoid rather than depressed. One begins to lay bare the terrified infant in retreat from life and hiding in his inner citadel, the problem of my three patients of twelve years ago. Fairbairn writes: 'Such an individual provides the most striking evidence of a conflict between an extreme reluctance to abandon infantile dependence and a desperate longing to renounce it; and it is at once fascinating and pathetic to watch the patient, like a timid mouse, alternately creeping out of the shelter of his hole to peep at the world of outer objects and then beating a hasty retreat' (1952, p. 39). Two more recent cases were decisive for me. (i) A married woman of fifty, during a prolonged hysteric phase, dreamed of a hungry, greedy, clamouring baby

hidden under her apron, the symbolic representation of an active orally sadistic infant who had to be kept under control or none would like her. When she had worked through that level she became markedly schizoid, quiet, shut-in, silent, finding it hard to maintain any interest in life, beginning each session by saying 'You've gone miles away from me'. She now produced a phantasy of a dead, or else a sleeping baby buried alive, in her womb, and felt that she had a lump inside her tummy as if pregnant. (ii) The second patient was a male who had an earlier period of analysis of exceptionally sado-masochistic oral material and intense conflicts over both sexual and aggressive impulses which he controlled with great difficulty. He reached a stage where his original guilt-depression faded away and he could carry on as a successful if obsessionally hardworking professional man. Then an unusually severe run of family troubles broke him down again. When he returned to treatment he was plainly struggling against a powerful regressive drive, feeling exhausted, and having phantasies of an infant wrapped away in a warm and comfortable womb.

It was this material that first suggested to me that what Fairbairn calls the *libidinal ego*, corresponding to the libidinal aspect of the Freudian 'id', the dependent needy infant, itself undergoes a further and final split. It is already split off and isolated in the personality by repression, by the Freudian ego and superego, or what Fairbairn calls the central ego and antilibidinal ego. To this internal persecution the infantile ego produces a double reaction of 'anger and fight' and also 'fear and flight'. This leads to the deepest ego split of all, into an active oral ego and a helpless regressed ego as a final hidden danger. Psychoanalysis has taken full account of the 'ego vicissitudes' of anger and the aggressive or fighting impulses in face of threat. It has not taken the same full account of the 'ego vicissitudes' of fear and flight from life, and so has never satisfactorily fitted regression into the conceptual framework. In practice, regression is usually treated as a nuisance to be checked. I believe regres-

sive trends are in fact derived from a structurally specific part of the total self which is deeply withdrawn, the schizoid ego *par excellence*, the hidden self in the schizoid citadel. It has undergone a two-stage withdrawal, first, from a persecutory outer world of external bad objects; and secondly, from a persecutory inner world of internal bad objects, and above all the antilibidinal ego (Guntrip, 1961 *b*).

Psychotherapy may produce valuable results *en route*, but it cannot be radical unless it reaches and releases this lost heart of the total self which is not only repressed, but also too terrified to re-emerge. So far as I can see, though our terminology is different, this is what Winnicott is saying when he describes a patient as having had a successful Oedipal analysis, and then later coming to him for a treatment which he calls 'therapeutic regression aiming at the rebirth of the true self' (1958, p. 249, 'Mind and its relation to the psyche-soma').

This problem justifies us in saying that what psychoanalysis has discovered so far is just how difficult radical psychotherapy is. It presents us with two final problems for analytic research.

(1) First that of 'resistance to treatment', which now turns out to be due not simply to unconscious guilt, but to sheer fear of collapse into a self which is too weak and fear-ridden to face life. The infantile dependence which Fairbairn regards as the true cause of neurosis is something which the patient has been taught culturally to despise, and emotionally fears as undermining his efforts to carry his adult responsibilities. He fights against any real dependence on his therapist, believing that it will throw him back on the weakest part of his personality, rather than be a position of emotional security setting him free for regrowth. What Balint (1952) calls 'primary passive love' is the necessary starting point for his 'new beginning', when the basic ego has been too badly damaged in early childhood. But the patient has spent his life fighting against just this, and feels intense contempt and self-hate over it. This is more elementary

than the moral super-ego; not fear of bad impulses but fear of weakness. This, I think, is the ultimate meaning of Fairbairn's antilibidinal ego. It enshrines the frightened child's fear of his own weakness, his desperate struggle to overcome it by self-forcing methods, and by the denial of all needs, especially passive ones.

Fairbairn's antilibidinal ego (the denial of needs) is thus the patient's main defence against the 'dangers' of regression, and is therefore the chief source of resistance to a good therapeutic relationship with the analyst by means of which a controlled constructive regression could be undergone to whatever extent it may be necessary to make possible regrowth. At the same time it illuminates Fairbairn's view that resistance is due to 'libidinal cathexis of the bad object' (1952, pp. 72 ff.), for if the patient cannot let himself have a good object, he must cling to bad objects, either in phantasy or fact, or risk the loss of his ego. One sees patients undergoing self-imposed tortures mentally which they do not seem able to give up. They cannot trust themselves to the therapist because, having been let down by their environment in infancy, they had to keep going by a fanatical internal cult of enforced independence which they are afraid to relax (Guntrip, 1960). Hence Fairbairn's further view that the patient struggles to maintain his neurosis as an 'internal closed system' (1958).

(2) If at last the patient can undergo and accept a therapeutically controlled regression, the second and worse problem emerges. He will experience terrifying states of despair, feeling utterly shut-in and hopeless about any rebirth. For a long time he oscillates between regression and resistance. The analysis of Oedipal conflicts seems to me relatively straightforward by comparison with the analysis of the complex infantile schizoid fears and persecutory anxieties which originally prevented the growth of a strong basic ego, and now bar the way to the rebirth of the lost heart of the self. One patient recently reported that while she was sitting in a bus she suddenly

had a queer purely mental experience. 'I felt I was nobody, neither body, soul nor spirit. I felt that I, the real "I", was nothing at all.' Here is the patient's discovery of the basic need to find a real self.

The problem is constituted, not only by the existence of persecutory fears, but also by the persistence of an undeveloped, weak infantile ego state; a vicious circle in which the fears block ego development and the weak ego remains exposed to fears. Psychotherapy has to provide a new security in which a new growth can begin. Just how afraid the patient is, is shown in a letter from the woman of 48 years already referred to.

I am consumed with fear. I have always been and still am terrified of everything and everybody. Terrified of doing things, too afraid to live at all. All my life I have been running away and trying to hide. That is what I am doing here in this job and this flat. I want to hide and be undisturbed by the world and other people. I want to sleep and let the world go by. Yet there is another side of me that longs to *live*, and wants to be able to do things and live an interesting life free from *fear*. But it is such a struggle always fighting *fears*. The prospect of marrying has brought this to the fore. I want love desperately yet I am afraid to accept it or even to believe in it. I have been trying to force myself to go the pace alone but I need help desperately.

So far as I can see the very real gains and developments in her 'ego of everyday life' as a result of the earlier orthodox analysis, enabled her to face the uncovering of a regressed infant in herself. But, until that was regrown, no therapy could be complete. Is it safe or possible to go so deep with everyone?

At this point three practical problems arise, two of them being related almost as mutually exclusive opposites. The question can be asked, on the one hand, whether increased knowledge of the regressed infantile ego in the schizoid citadel will enable us to uncover it more quickly and so shorten the ever-lengthening process of psychoanalytical treatment? In any absolute sense I cannot think this is practicable. Premature interpretation of the existence of the most withdrawn part of the complex ego will yield no better result than premature interpretation of any other problem. The patient will either not understand or else grasp the meaning only in an intellectual way. If the patient is nearer to the emergence in an emotional way of this basic withdrawnness, interpretation of it before he can stand it will only intensify his defences. There is no short cut. The patient's strongest defences are permanently mobilized to keep his regressed ego and his passive needs hidden, for when they begin to emerge he feels he is really 'breaking down'. All the Oedipal and compromise positions involved in his defensive system must be patiently worked through and in that process the patient comes to feel strong enough and well enough understood and supported to face the ultimate test of bringing the fear-ridden infant into the treatment relationship.

If we were to try at once to drive straight to the tap-root of all problems, the schizoid problem, we would not only risk fitting the patient into a theory, block him by trying to take up conflicts not in the natural order of their unfolding, and learn nothing new, but a problem of an opposite kind would arise; namely, granted that the schizoid problem is the ultimate one, if we insist with too narrow and rigid logic on this, we may fall into the trap of thinking that nothing else matters. This would lead to premature attempts at reduction of all problems to this one problem, in psychotherapy, much as Rank (1929) thought he could go straight to his 'birth trauma' and clear everything up quickly. That would be a delusion. The patient will dictate how fast the analysis can move by what and how much he can cope with as it goes along. One can only deal with what the patient presents and let the next phase grow out of that. I have never felt able to do more than keep a sharp lookout for any signs of 'withdrawnness' the patient actually does present, and take care not to hold up the analysis by treating conflicts over sex and aggression as ultimates when the patient is ready to go behind them.

We cannot afford to concentrate attention exclusively on any one thing, whether it be the Oedipal problem, the depressive position, or schizoid withdrawal and regression. We can only recognize that psychoanalytical investigation has discovered these problems in that order as it has worked deeper. We must use all concepts which are relevant to whatever the patient presents and keep an open mind for anything 'new' he discloses. Psychodynamic theory will not come to a final closure in our generation. Assuming that, so far as we can see at present, the schizoid problem is the basic one, certainly not all patients begin by presenting this kind of material. If they do, they are more than averagely ill, and even then its complexity is enormous and we know all too little about primary ego development as yet. So we must not allow theory to become dogma but use it as a signpost.

The third question that will very likely be raised is that the patient *wants* to be treated as a baby, with the implication that he should not be indulged in this. I believe that to be a grave misrepresentation of the case. There is an infant in the patient who actually *needs* to be accepted for what he is, by being helped to whatever degree of 'therapeutic regression' proves to be necessary. But there is also a 'forced antilibidinal adult' in the patient who hates this. If the patient senses that the therapist is on the defensive against his deepest needs, this will have the effect of forcing them to the front, and he may well be driven to become demanding and try to manipulate an analyst (parent) who basically rejects him. If, however, the patient slowly realizes the analyst will accept and help the baby in him, it has the effect of bringing his antilibidinal defences into the open, and we witness the intensity of the patient's resistance to treatment as a struggle *not* to depend on the analyst for help. This is a situation the analysis of which leads to far more real progress towards a more secure, relaxed, non-anxious and spontaneously loving personality. We need to know more about the processes of rebirth and regrowth of the profoundly withdrawn infant self hidden in the schizoid citadel, and what kind of relationship of the analyst with the patient is required to make that possible. One patient said simply: 'If I could feel loved, I'm sure I'd grow. Can I be sure you genuinely care for the baby in me?'—a statement which makes it clear that fundamentally what the patient is seeking and needing is a relationship of a parental order which is sufficiently reliable and understanding to nullify the results of early environmental failure.

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A multi-ego theory of libido-destrudo dynamics and mental illness

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Psychoanalysis has long since established the fact that libido and destrudo (aggression energy) are constituents of the human psyche. It is this writer's contention that these energies, inherited from man's predecessors in the course of evolution, come into conflict with a particular development reached in the human infant; namely, an advanced cerebral cortex and ego structure at the time of birth. The homo sapiens is born as a cognitive rather than a conative animal. He has an awareness of the objects that are his goal, the breast and mother, and as a consequence he attempts to express love directly toward his conscious objects, as contrasted with the instinctual reaction of the lower animal. For reasons to be explained later, he finds this direct expression of libido a futile task, giving rise to feelings of aggression which also fail to affect these objects. During the first three or four months of life a variety of frustrations and distortions ensue, *independent of the mother's behaviour*, which universally result in a psychic development that I view as a detrimental factor to be found in all human beings, as well as the dominant force in mental illness. I am referring to the formation of an aggression-laden subego structure, *and I advance this conception as the logical development and conclusion of Freud's 'death instinct' hypothesis*. Whether this unconscious subego will activate mental illness in a particular individual depends on the quality of his relationship with his mother (and to some extent the father) from the earliest months to approximately adolescence; in a limited number of cases the dependent factor involves a non-parental relationship or experience. In this paper I shall attempt to explain why this sub-ego structure is an invariable outcome of infancy and how it plays an instrumental part in the various forms of mental illness. Several theoretical conclusions that give new significance to the ego-ideal and superego will also be discussed.

As the text and several footnotes of this paper indicate, this writer's viewpoint of psychodynamics has been influenced to a considerable extent by the concepts advanced in a series of papers by the distinguished Scottish psychoanalyst, W. R. D. Fairbairn.*

I. INTERNALIZED OBJECTS

It seems to this writer that virtually no psychoanalytic concept has failed to receive its due regard as the subject of internalized objects. As is well known, Melanie Klein and her group were the first to conceive of this psychological phenomenon, particularly with respect to the vicissitudes of infancy. Mrs Klein's discerning observations of the infant's relationship with internalized objects constitute an important advancement to the field of psychopathology. However, the significance of her contribution was profoundly expanded when W. R. D. Fairbairn ascertained the *structural* quality and *dynamic* property of internalized objects. In his explanation of dynamic internalized objects, Fairbairn states (p. 132): '...I must now draw 'the logical conclusion of my theory of dynamic structure and acknowledge that, since internal objects are structures, they must necessarily be, in some measure at least, dynamic.' This crucial and

* All references and quotations of Dr Fairbairn that appear in this paper are from his text, *Psychoanalytic Studies of the Personality*; published in the United States as, *An Object Relations Theory of the Personality*. (See 'References' page for publishing data.)

explicit distinction of these unconscious components provides us with a decisively important understanding of psychic composition. For while the Kleinians originated the concept of internalized objects, they tenaciously adhere to the Freudian technique of emphasizing the patient's repressed phantasies and impulses (attributable to objects), and in so doing have subordinated the matter of internalised objects to a secondary role.* This approach precluded the recognition that phantasies and impulses are but a product of the dynamic influence of internalized objects. Thus, to give the major attention to phantasies, memories, or impulses is comparable to an effort to extinguish a fire by concentrating one's energy towards the elimination of the smoke, albeit this may indirectly help.

It is apropos to state at this point that while I am in agreement with Fairbairn on his formulation of the dynamic and structural characteristics of internalized objects, I consider it a matter of substance to take issue with several of the other conclusions he reaches on this subject. As stated in the opening paragraph of this paper, I view the primary source of mental illness as emanating from a basic subego structure, whereas Fairbairn envisions the effects of internalized bad objects as the operative factor in mental pathology. I certainly agree with Fairbairn that bad objects are a decided detriment to the personality—but for quite a different reason. The disparity in theory rests on my contention that bad objects could be readily repressed and controlled if it were not for the damaging influence of the aforementioned subego. It is this latter component that makes repression nearly impossible and which uses these objects as a means to weaken the ego for its sadistic intentions. The essence of this paper concerns the activity of this subego structure, which resembles a 'death instinct' process in the personality, and the

ego's attempt to defend itself against this destructive entity.

The question of the primacy of good objects is without doubt the point of greatest divergence between Dr Fairbairn's theoretical position and mine. He asserts that good objects are internalized only to neutralize the effects of bad objects; the internalization of any object (good or bad) is contrary to the ideal personality. From my viewpoint, the internalization of good objects is not only desirable but absolutely essential. The ego develops and takes its form by a union and identification with them. An ego prevented from an integration and identification with its good objects is like a 'house' without walls, and this analogy could readily be applied to the shallow, almost formless personality of the schizophrene. Internalized good objects render the ego love energy, and provide the ego with a feeling of acceptance and value. They afford the child (and later, the adult) the strength to meet a world that, from his perspective, often appears overwhelming. Good objects are internalized to perpetuate the love and kindliness of the parents, who represent the child's security for survival. Adult maturity and the ego's ability to integrate its good objects are indicative of synonymous properties. I regard the internalization of multiform objects as a specific feature of the human nervous system, making possible the various relationships of love and hate that human beings act out. Without the capacity to internalize persons as good objects, along with subsequent projection, love for another individual would involve a crude, conative, instinctive reaction, as in lower animals, or perhaps simply a stimulus-response activity. Finally, good objects carry the morality and virtue of the individual's parents, a process that transfers and perpetuates the moral structure of society. Man would be as amoral as his less developed members of the animal kingdom were it not for his ability to internalize good objects, as will be suggested in the section dealing with the ego-ideal.

The deleterious quality of *bad* objects makes their examination a central issue of the

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* Fairbairn states (p. 62): 'I now venture to formulate the view that what are primarily repressed are neither intolerably guilty impulses nor intolerably unpleasant memories, but intolerably bad internalized objects.'

analytical process, and from the analyst's interpretation the patient is encouraged to introspect and consciously re-experience his relationship with them. Bad objects are the result of the introjection of the parent(s) who rejects the child and his expressions of love, criticizes him, and/or belittles the child, or a parent who acts immorally, particularly in terms of sexual behaviour. Internally an object retains the same traits and characteristics as possessed and manifested by the offending parent during a particular external experience. As Fairbairn has explained, these internalized structures are dynamic; and, accordingly, they have the capacity to render aggression energy onto the ego (just as good objects render libido). Hence, bad objects vivify an internal perpetuation of the bad parent(s) *and* his destructive behaviour and attitude towards the child. The ego suffers these experiences repeatedly from internalized objects during those periods when it is unable to check them with repression, although I regard this suffering as minimal and secondary as compared to that imposed by the subego mentioned above.

Fairbairn's important contribution to the *structural* nature of internalized objects leads us to a position that he did not adopt, but which I feel is incumbent upon us to recognize in view of established points: if objects have structure and are dynamic, it logically follows that they can only be composed of 'ego material', i.e. they represent splits of the ego; they are diminutive ego entities (ego fragments). (The ego-quality of internalized objects is of vital importance with regard to the phenomena of guilt and depression, as will be discussed.) However, despite their (limited) autonomy as ego structures, internalized objects generally relate with the ego as they were internalized, i.e. as the parent treated the child at the time of internalization (ego splitting).* This internalization process is the equivalent to what Melanie Klein has called 'projective identification'.

Viewing internalized objects as structural, ego entities requires a revision of the position

frequently expressed by members of the Kleinian group, namely, that these internal components exist as phantasy-function. This contention leads to an incongruity when these writers then speak of phantasies that interrelate with objects; for such a proposition would entail a phantasy concurrently dealing with another phantasy, which is immeasurably difficult to contemplate. Moreover, the autonomous features often attributed to internalized objects are beyond apprehension if these objects are perceived as consisting of phantasy. An independent interchange with the ego is certainly inconceivable since a phantasy is an operation of the ego itself, *ipso facto*. As an *ego* structure, however, not only is disjunctive status and semi-autonomy possible but the faculty required to render libido or aggression energy is also comprehensible.

II. THE AUTHOR'S VIEWS ON BASIC ENDOPSYCHIC PHENOMENA

A. *Infancy trauma: inability to cathex libido*

At the outset of this paper it was stated that, as a cognative animal, the human infant is able to perceive the breast and mother, to which it unsuccessfully tries to transmit libido. This is

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* There would appear to be two kinds of ego splitting: (1) When an object is internalized ('projective identification'), which corresponds to a momentary submission of consciousness to the external object. (2) A deliberate attempt by the conscious ego to remove a traumatic, guilt-ridden, immorally destructive, or otherwise untenable psychic state. In this case the undesirable 'ego state' is split off from the main ego. Besides weakening the ego, these splits may later haunt the ego by virtue of their own autonomy. *It is critically important to recognize that a split of the ego is not an elimination of 'ego material' but a division in autonomy. Each time a split takes place a new ego is born, however minor its constitution may be.* Cases of multiple personality, ego splitting in its most extreme form, can leave us in no doubt that the ego is capable of being split into secondary egos.

in contrast to the instinctive object relations of the conative animal. The question confronting us is: if the mother is kind and loving to her baby, why should he not be able to reciprocate libido during the earliest months? The answer, as this writer views the matter, can be found by an extension of Fairbairn's work on structures and energy. Contrasting the Helmholtzian scientific viewpoint that prevailed in Freud's day, Fairbairn cogently argues that current thinking no longer is sympathetic with a directionless and structureless state of energy phenomena in the universe: 'By contrast, if we conceive of energy as inseparable from structure, then the only changes which are intelligible are changes in structural relationships and in relationships between structures; and such changes are essentially directional' (p. 126). 'I have come to adopt the principle of dynamic structure, in terms of which both structures divorced from energy and energy divorced from structure are meaningless concepts' (p. 149). 'As has already been pointed out, of course, neither libido nor aggression can be considered as existing in a state of divorce from structure' (p. 115). In a word, energy is dependent both on its source and direction from a structure, be it a primary ego or secondary ego (internalized object). Thus all endopsychic dynamics represent the relationship of structures.

Now, if libido, an energy, must emanate from a structure to reach a structure on an endopsychic level, indeed, there would seem to be no reason why the same law should not apply on the exopsychic level. It immediately becomes apparent, however, that there is no media for libido to reach an external object from the psyche. *Literally speaking, it is impossible for one person to love another person. What we love is the internalized object of that person, projected onto him during his presence.* Thus all libido relations are endopsychic in the final analysis. (This point of view should not be confused with the philosophical doctrine of solipsism.)

However, in giving prominence to the intrapsychic conditions that constitute the sensation of being in love, I would certainly agree that the mature, healthy personality is aware of the importance of the external object, since it activates its internal counterpart, as well as providing a physical form for internalized objects, with subsequent acting out. The conscious ego, of course, thinks in terms of the external object, but the *emotional sensation* that tempers, if not determines, the relationship with an external object is predicated on the conditions that prevail in the unconscious, i.e. the nature of the objects that the unconscious portion of the ego is (and can) relating with and, therefore, the nature of the objects that can be projected.

The infant, of course, is not born with any internalized objects, and unfortunately for the infant he is not aware that he must first internalize the objects he covets before his libido can reach a target. In vain he desperately attempts to find an entity upon which to cathex his flow of libido. External figures not only fail to satisfy this need but produce in the infant the feeling that he is being drained of libido, as they seemingly appear to invite a cathexis by their presence but fail to yield themselves, as the infant sees it, to that purpose. Melanie Klein has given us an extensive insight into the paranoid-schizoid features of these early months. She describes the infant's enormous fear of external figures, which arises as his rage, frustration, and helplessness are attributed to them. External objects take on a most destructive and annihilating complexion, and in an effort to control them the infant

* The phenomenon of romantic love is a product of projecting one's good objects onto another person. This projective process results in a libidinally idealized perception of the external object; thus, the internalized version of the external object embodies the perfect, ecstatic qualities of the ego's good objects from childhood. The blissful objects of infancy are also activated and projected during the relationship of romantic love, and they impart the intensity of libido that heightens the sex act. The heterosexual direction of the projective process of good objects will be discussed under the section dealing with homosexuality.

internalizes them. Thus the first objects to be internalized are of a highly threatening nature, although this circumstance will act as a paradigm for the internalization of good objects. As the infant reaches the second month, he has undoubtedly accumulated some good objects, but he primarily continues at the impossible task of attempting to expend libido externally. Throughout the period under discussion the young child seems to find only a rejection of his love, regardless of the mother's attitude or conduct, and there develops the intolerable feeling that no one will accept his love because, as he sees it, they consider his love to be bad and destructive.* This condition is intensified as the seemingly rejecting external objects are internalized. The infant concludes that badness must be the nature of his love, an affect that reaches its climax near the end of the third month.

B. *The sadistic ego*

As Melanie Klein has described, the infant attempts to rid himself of destructive or persecutory sensations by the technique of ego splitting. But the ubiquitous condition of feeling his love as bad confronts the infant as a far more devastating and general problem. He is closely identified with his libido, his life energy and sense of goodness combined, and the absolutely untenable state of feeling one's love to be bad and destructive is not difficult for us to appreciate. There is the added danger of destroying with bad love the few good objects he possesses at this stage. The objects

which were internalized as libidinally rejecting intensify the infant's traumatic feeling that his love must be bad. There can be no doubt that the infant's ascending recognition of the mother as an individual (the 'depressive position') greatly exacerbates his trepidation of destroying her with bad love as well as by the projection of bad objects.

The infant again resorts to the technique of splitting, however, on this occasion he is left with no alternative but to split off his ego on a grand scale, resulting in total amnesia of his first three months. Only the core of the ego and its few good objects remain. *The split off ego segment, in which love was conceived of as bad, assumes the possession of 'bad love', i.e. aggression energy, and the great tormentor of every personality is so born.*

The terrifying persecutory and libidinally rejecting objects of the first three months become the nucleus for the new split-off ego to identify and develop by, which gives it a constitution characterized by belligerence and destructive pursuit. I have named this subego the *sadistic ego*, for that indeed depicts its function in the personality. It is held in check by a basic repression of libido, which is augmented in healthy individuals by a repression of aggression energy. In my considered judgement, psycho-dynamics, both normal and pathological, are unintelligible unless one takes into account the influence of the sadistic ego and the ego's various defence measures to protect itself against that entity.

C. *The ego-ideal*

Freud's writings indicate that his concept of the superego evolved from his hypothesis of the ego-ideal, which appeared considerably before he postulated his theory of the superego. And, as their nomenclature indicates, Freud

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* The concept that the individual may come to regard his love as bad and destructive (as a consequence of maternal rejection) was first advanced by Fairbairn in 1940, *Schizoid Factors in the Personality*, published in *An Object Relations Theory of the Personality*, op. cit., and it is regrettable that this profound formulation has not as yet achieved wider recognition, notwithstanding its subtle and abstract character. This important Fairbairnian contribution is utilized in a later section of this paper, 'The Schizoid Nucleus'. In the above context, however, its use is independent of the factor of maternal rejection.

* The torment ranges from schizophrenia, on the one hand, to internal conflicts and uncertainties as to one's abilities to accomplish set goals, the merit of accomplishments, the purpose and meaning of life, possibilities of failure in various endeavours, *ad infinitum*.

associated an *ego* function to both of them. If Freud had taken into account the capacity for variability of ego structures, perhaps he would not have found it necessary to replace the ego-ideal with the superego. From my viewpoint, good objects (which, as discussed, are each a diminutive ego) collectively represent *both* the ego-ideal and the superego. In their primary function, good objects act as the ego-ideal—as the loving, ideal parents which were internalized throughout infancy and childhood. Thus good objects and the libido they render serve to enhance the integrity, stability, and strength of the ego. However, good objects, as ego entities, can upbraid the ego when it has committed an act of behaviour (in phantasy or actuality) that the good parents would disapprove. Good objects have the capacity to reprimand the ego with a mild reproach of aggression, which is felt as *guilt*, and under these circumstances good objects function as the superego. Sustained or very severe guilt constitutes literal *depression*.*

Internalized objects, as contrasted with the sadistic ego, are not highly organized ego structures, and good objects could not inflict guilt on the ego without an additional factor. Behind the entire process of discord with good objects lies the sadistic ego. It is the latter which seizes on any actions, thoughts, wishes, or behaviour of the ego which involve a dis-

crepancy with what good objects would deem moral or proper. For purposes of torturing the ego, the sadistic ego attempts to terrify the ego with the accusation that its behaviour or contemplations have greatly offended the morality of good objects, and that the ego is not entitled to maintain its relationship with them any longer, i.e. the ego is made to feel no longer worthy of its good objects. The prospect of having to relinquish its good objects horrifies the ego, and in an effort to purge itself of wrongdoing and once again become acceptable to good objects, the ego *voluntarily* requests to be punished—to pay the penalty or debt that will cancel its alleged badness. Thus the ego 'bares' and admits its transgression to its good objects and solicits an aggressive reproach (guilt) from them that will scourge the ego of its wickedness, purifying the ego so that the *status quo* with good objects may be deservingly resumed.*

D. *Sadistic ego activity*

The incessant goal of the sadistic ego is to inflict pain and misery onto the ego. The sadistic ego is charged with aggression energy, which it utilizes to implement its barrage of accusations designed to injure the ego. The latter finds this adversary ready to take advantage of any situation, condition, or event that is unfavourable to the ego, be it external or internal. In the neurotic or psychotic ego there is a reduced ability to check the endless flow of insidious denunciations levelled in its direction.

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* Fairbairn makes a distinction between depression and 'a sense of futility', which frequently is loosely termed 'depression'. A 'sense of futility' is a schizoid phenomena, and in the majority of cases represents the painful condition that drives the patient to seek analytical assistance. I agree with Fairbairn's illuminating distinction, although I do not concur with the infancy etiology that he subscribes to each. I believe a 'sense of futility' is derived from the ego's unsuccessful and sustained battle with the sadistic ego, with maternal rejection as the central issue. Depression most closely approximates sorrow or grief, as will be discussed in a later section. It is interesting that Fairbairn's dichotomy of pathological types is currently correlated by the two major divisions of psycho-pharmaceuticals: the phenothiazines and the anti-depressants.

* This approach closely parallels the Freudian position regarding guilt and a need for punishment. As enunciated by Fenichel, this mechanism involves a process in which the 'destructive impulses' are directed against the ego, culminating in the sensation of guilt and the unconscious need to be punished. If we equate 'destructive impulses' to the sadistic ego, and if we equate the ego's 'need for punishment' to the ego's need to be deserving and worthy of its good objects via 'flagellation', the psychic operation outlined above is quite consistent with Freudian theory. (Cf. Freud's 'A Child Is Being Beaten'.)

In order to gain the upper hand, the sadistic ego must first weaken the ego. Almost without exception, *it effects the weakened state by a breaking down of the ego's relationship and identification with its internalized good objects*, which, as stated earlier, are the bulwark of the ego; *and this disjunction should be regarded as the pivotal point of all psycho-pathology.* How is it, then, that the mentally ill person is unable to prevent the partial or complete loss of this all-important integration of good objects? Why does he not also make use of the aggression energy at his disposal to restrain the sadistic ego, as the healthy individual does?

The ego's inability to aggressively suppress the sadistic ego is a consequence of what might be termed 'endopsychic blackmail'. The nature of the blackmail will largely determine the nature of the patient's symptoms, which in turn give rise to the various nosological types. In using extortion, the sadistic ego is effectively able to frighten the ego into a self-sabotaging course of action.

In this writer's judgement, inner blackmail, and therefore the numerous nosological types and designations, may be generally categorized into two primary classifications:

(1) Libidinal rejection, particularly from the mother, resulting in the internalization of libidinally rejecting objects (subegos).

(2) The internalization of: a forbidden sexual wish, e.g. incest; destructive feelings for a parent or sibling; a repressed experience having immoral or socially forbidden characteristics. In this second division, the internalized component is crystallized as guilt drives the ego to split off the unacceptable wish, feeling, or experience; thus such a component becomes a separate subego entity, which explains its enduring existence in the personality.

Those individuals of the first category (maternal libidinal rejection) are pre-schizophrenic, if not manifestly schizophrenic, and may aptly be termed 'schizoid'. This group is the more common of the two classifications, and often schizoid dynamics may be found in the second category.

Individuals of the second group are characterized by the guilt and depression that ensue from the sadistic ego's charge that internal conditions make the ego unworthy of its good objects. This category of persons might be designated 'guilt-depressoid'.*

The presence of a large number of internalized bad objects creates great problems for the schizoid ego; not so much because of the adverse effect these objects *per se* have on the ego, but rather because of the vulnerability they cause the ego. Even though bad objects are hostile, cruel, rejecting, etc., they nonetheless represent a parent figure, and the ego is confronted with the inescapable consequence of suffering guilt and the disaffect of good objects were it to repress bad objects with aggression energy. Thus the sadistic ego leaves the ego no choice but to attempt the repression of bad objects with libido.

Repression of bad objects with libido is set with its own dangers. The ego, of course, must repress bad objects to avoid pain, but the use of libido on these objects duplicates and reinstates the original trauma in which the libidinally rejecting mother (or father) spurned the child and his expression of love. The sadistic ego takes advantage of the ego's dilemma, constantly threatening to force the ego to acknowledge parental rejection and the contingency that seemingly indicates its love is unacceptable and, therefore, bad. This is a highly formidable threat, *for the ego realizes that if it must acknowledge its love as bad, it*

* The terms 'schizoid', 'paranoid-schizoid position', and 'depressive position' were, of course, introduced by Melanie Klein and W. R. D. Fairbairn. In utilizing this nomenclature, I should like to make clear that the categories I delineate are *not* representative of stages in infancy. The above-mentioned psychoanalysts applied these terms to indicate the characteristics of specific phases of the infancy period. My application of them covers developments that may occur at any point in an individual's life, although I regard the years prior to puberty as most decisive in the great majority of cases. Moreover, the dynamics I outline pertinent to the 'schizoid' and 'guilt-depressoid' types are based exclusively on the ego's inability to effectively suppress the sadistic ego.

must relinquish all of its GOOD *objects out of the fear it would destroy or contaminate them with bad love.* This predicament is the central problem facing the schizoid; other methods employed by the sadistic ego in its efforts to divorce the ego from its good objects are discussed in the next major subdivision of this paper, 'The Schizoid Nucleus'.

The 'guilt-depressoid' type, like the schizoid, is endopsychically blackmailed, but the issue(s) involved, while all characterized by an incompatibility with the standards of morality of good objects, has a greater potential variation than the rather specific dynamics of the schizoid condition. Moreover, such issues (e.g. destructive wish, incestual desires) affect different individuals diversely, which is largely attributable to the level of moral standards and requirements embodied by the good objects of a particular person. Generally speaking, the guilt-depressoid type is manifest in one of several nosological types: manic-depressive psychosis, obsessional-compulsion neurosis, melancholia, and in some cases, alcoholism. Paranoia and homosexuality reflect a combination of both the schizoid and guilt-depressoid groups, with a few distinctive features of their own. The dynamics of the various pathological types are discussed in §IV of this paper.

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Not only does the sadistic ego utilize for its destructive purposes those bad objects and guilt-imparting components that have been internalized, but it is primarily responsible for the intensity of their internalization, in the first place. For when the parent presents himself as belittling or rejecting to the child's ego, it is the sadistic ego which magnifies the offence or trauma beyond the proportion of actuality by inciting the child's anger (e.g. 'You are a fool to tolerate such condescending treatment'),* or by activating previously internalized bad objects during each rejective experience, which are then projected onto the rejecting parent. Thus each successive experience takes on a more deleterious quality than its predecessors, regardless of the actual degree

of the parent's malevolent treatment of the child.

III. THE SCHIZOID NUCLEUS

Since the sadistic ego is, as its name implies, an *ego* structure, it must be accorded the qualities of autonomy, and hence, it has the mobility to utilize every vulnerable weakness of the ego in its relentless attack on the latter. The endopsychic blackmail exploited by the sadistic ego may, of course, widely differ in various individuals; but undoubtedly the most common form employed to sabotage the ego pertains to the presence of libidinally rejecting internalized objects, particularly of the mother and the resulting susceptibility of the ego to the accusation that its love is bad and destructive. Where libidinally rejecting objects predominate in the individual's unconscious, a schizoid condition or outright schizophrenia is the unavoidable outcome. Moreover, a schizoid state, in addition to greatly weakening the ego, reduces its ability for ordinary repression and renders normal defences ineffectual. Thus, the schizoid state increases the traumatic potential of any unfavourable situation, whether it pertains to libidinal rejection or not. The schizoid child, especially, is susceptible to trauma that may superimpose additional pathology onto his original condition, i.e. he has a low threshold for tolerating the adverse circumstances the healthy child would take in his stride. To a lesser extent, this also applies to the adult schizoid.

There would appear to be some rather general mechanisms operating in the schizoid personality, ranging from psychotic to neurotic. These mechanisms are mainly defensive in essence (with the exception of the first one:

* Needless to say, the dialogue that appears in quotations throughout this paper comprises an attempt to convey more readily the primitive, non-verbal communication of affect. This writer is of the opinion that the nature of psychological material often does not lend itself to formal, abstract exposition, and the use of dialogue greatly facilitates comprehension, for patient and publication alike.

complete schizophrenia), and several of them may be operative in the same individual. They are as follows:

(1) Libidinally rejecting internalized objects are used by the sadistic ego as evidence that the ego's love is unwanted (rejected) and, therefore, bad and destructive. The ego attempts to deny the existence of bad objects with libidinal repression. This method is very precarious, indeed, for the ego is using love energy to repress the very objects that reject its love, and the sadistic ego ultimately will confront the ego with that debilitating dilemma. Before the emergence of a complete schizophrenic breakdown, the ego resorts to simple denial of the rejection in so far as libidinal repression succeeds in keeping bad objects at bay. Eventually the sadistic ego is successful in substantiating the rejection of the ego's love from bad objects. The inevitable indictment that its love is bad and destructive faces the ego. This places the ego in a seemingly hopeless bind: If it does not attempt to repress bad objects libidinally, it suffers their cruelty; but to continue to use love energy for repression would be a duplication of libidinal rejection, leaving the ego helpless to deny the sadistic ego's accusation that its love is bad and destructive. The ego is faced with the impossible task of attempting to execute two contrary actions simultaneously. (As stated earlier, the threat of guilt and depression prevents the ego from repressing bad objects with aggression energy.) But the ego's dilemma is increased a hundred-fold when it is confronted with the accusation that its bad and destructive love will contaminate and destroy its *good* objects. In fullblown schizophrenia the *status quo* is represented by the ego's excruciating concession to relinquish its precious good objects, using libido as a repressive force, but still finding no reprieve as it is unabatedly and unmercifully charged with contaminating and destroying its good objects with the libido being used for their repression. The ego is both separated from its vitally important good objects and is left with the devasting sensation that its own love is bad. The ego is utterly demoralized, has no feeling of worth, and has no will for the continued repression of *bad* objects, which are then released and add to the ego's total suffering. The loss of good objects leaves the ego poverty-stricken, and the flow of aggression from the sadistic ego saturates the ego with the feeling of impending disintegration. As one schizophrenic patient put it, 'This endless war inside isn't worth the struggle any more'.

Internalized rejecting objects and the impending charge that his love is bad and destructive combine to promote the sensitive nature and 'childish behaviour' of the neurotic schizoid. With a justification not always appreciated or understood by his friends, he is *defensively* afraid of being 'hurt'. The schizoid is prone to interpret a loved one's actions as involving rejection (via projection), regardless of how trivial the offence, and frequently the schizoid's inner fear causes him to *imagine* rejection in the response of others. Unfortunately his defences mobilize an aggressive reaction, which, indeed, then does provoke an unfriendly or rejective response. A rebuff from a loved person (representative of good objects via projection) supports the sadistic ego's accusation that good objects are equally as unloving as bad objects. The inevitable charge that this proves his love is bad and destructive is, however, less potent and prolonged on the neurotic plane, and this sensation is felt and met as 'hurt pride' on the conscious level. The salient features of the schizoid condition are discussed below:

(1) Whenever another [external] person seeming simulates bad objects and draws the ego's attention to them, the sadistic ego, in its continuous effort to disassociate the ego from its internalized good objects, ironically plays the role of 'friend' and 'adviser', admonishing the ego as being a 'weak fool' for allowing itself to be libidinally hurt by bad objects. But the sadistic ego generalizes the matter by asking the ego: 'How can you accept good objects (of mother) when bad objects (of mother) want to hurt you? *Where is your pride*? Can you accept love from someone who [internally] also wants to *hurt* you?' Here the sadistic ego takes advantage of the state of megalomania that characterizes every schizoid patient.* In the name of 'pride' the ego is cajoled into disassociating (exerting repression) itself from its good objects. This is acted out as the schizoid reacts to the external person(s) present with 'righteous anger', obnoxious comments, or he may pout and sulk.

* For footnote see next page.

(2) Still playing the ironic role of 'benefactor', the sadistic ego upbraids the ego as the latter begins to feel a longing for its good objects and contemplates unification with them. Again utilizing the megalomanical features of the ego for purposes of destruction, the sadistic ego accuses the ego of being a fool and a dupe for the *dependence* and *longing* it feels for good objects (and loved persons). In effect, the sadistic reproach takes the following form: 'You do not have your good objects because they have "deserted" you. Surely your pride will not permit you to once again "forgive" and accept these objects. For the sake of your pride you must show them you do not need or want them.' In this stage the external acting out (a defence) takes the form of a contemptuous, callous repugnance toward loved ones and life in general. Defensively, the conscious ego assumes the attitude: 'Love relationships are dangerous and foolhardy. I'm completely independent; I don't need anyone for anything.' Not taking into account the fact that it was previously cajoled into disunion with its good objects, the unconscious ego takes the following attitude toward good objects: 'You have abandoned me, and I will not give you another chance to hurt my pride again.' Unfortunately an aggressive rebuke of good objects serves to prime the ego for a guilt reaction.

On the conscious level the ego's aggressive attitude is directed toward people libidinally important to the individual, as well as the established values of society. The schizoid attempts to safeguard himself against libidinal involvement with a terse, obnoxious demeanour, based on the

* As our literature has well established, the infant evinces the psychological trait of megalomania, and this basic narcissism would appear to be one of nature's methods of providing the infant with a defence against the nearly overwhelming factors of his early environment. In a wholesome environment, the child is genuinely loved, and the strength his ego gains from the resulting internalized good objects makes it possible for him to slowly dispense with his original megalomanical defence. In contrast, the schizoid's numerous bad objects greatly weaken his ego, and necessitate a continuation of the megalomanical defence, *which functions essentially as an exaggerated appreciation of one's love against the accusation that one's love is bad.*

premise: 'You can't reject my love, since I have *already* rejected *you*. So keep your distance.' The individual's anti-social stand reflects the ego's effort to [defiantly] demonstrate to good objects that it does not need or want them or the social probity they represent. However, taking an entirely self-sufficient stand (a defence) proves to be an expensive proposition. It costs the ego its vitally important relationship with good objects, and the individual's external relationships are void of the richness that comes in projecting onto another person the good objects of his inner world. Such an individual is observed as the caustic, characteristic cynic.

(3) Despite its declaration of independence, the ego sorely needs and longs for its good objects and their external representatives. The ego continues to find itself in the predicament of attempting to regain its relationship with good objects without sacrificing its omnipotent position (a defence), i.e. without exposing itself to the vituperation from the sadistic ego intended to injure the ego's megalomania—as would be the case if the ego made the 'first move'. (Such persons are incapable of apologizing.) In this stage the ego endeavours to indirectly *force* or *intimidate* the return of good objects, treating them as being responsible for the severance:

The ego assumes a self-destructive attitude which is intended to threaten good objects and pertinent persons: 'You'll be sorry for deserting me and refusing to love me. I'll destroy myself; then you'll feel guilty and sorry.' The individual adopts the role of martyr and ostentatiously displays the suffering he sustains from *bad objects*, with the intention of showing how terribly bad the internalized mother has become (generalizing). This suffering is actually invited as the ego partly decreases its repression of bad objects. The ego's purpose is to endure pain so it can more convincingly show its good objects its threat of 'self-destruction' and inculpate good objects for 'abandonment'. Concurrently the schizoid individual projects bad objects onto those persons around him; and he ceaselessly complains of mistreatment from these persons as well as dwelling on the pain he endures. Persecutory sentiments and hypochondria are frequently observed. Such is the fate of the individual having an excessive number of maternal bad objects in the unconscious.

In many schizoid individuals, the ego attempts

to find a solution for the ineffective tactics described above, by the employment of a subtle and rather complicated defence designed to counteract the sadistic ego and achieve limited union with good objects. In suffering pain from the bad objects that were *intentionally* released from repression, the ego, acting as a martyr, accepts this suffering as an indicting 'avengence' of good objects, in the manner discussed above; and the ego thereby outwits the sadistic ego by claiming it can accept good objects without a megalomaniacal sacrifice because good objects have sustained retribution and punishment and because a martyr (the ego) is entitled to compensation for his suffering. Thus the ego, within limitation, is able to enjoy the libidinal pleasure derived from this precarious, compromised relationship with good objects. Unfortunately, the sadistic ego demands continued proof that the ego is 'eligible' as a martyr; consequently the ego must *maintain* its suffering from cruel, bad objects. This combination, pain from bad objects and libidinal pleasure from good objects, constitutes a kind of covert masochism, which may lead to conscious, perversion masochism in certain cases (see §V, Sadism and masochism). The 'martyr defence' reaches the conscious level in the form of persecutory feelings and self-pity, which become the schizoid's *modus vivendi*. Neurasthenia and hypochondria are also prominent symptoms.

(4) In the quandary of attempting to secure its good objects without a megalomaniacal sacrifice the schizoid seeks to prove good objects do not and cannot abandon him, as verified by his ability to *control* them. Correspondingly, persons libidinally important to the schizoid, the external representatives of his good objects, are exposed to a brazen, audacious type of conduct: he creates 'test' situations whereby he endeavours to substantiate that he is loved without any commitment of his own emotional needs or feelings. He will make outlandish demands or requests of the other person involved based on the preconscious postulate, 'If you *really* do love me, you will comply to all of my demands'. Many marriages seem to be composed of such a relationship, with one spouse maintaining a pervasive control over a subjugated, acquiescing spouse.

Somewhat similar to the previous illustration, the schizoid will create test situations in which a loved person, usually a spouse, is subjected to periodic outbursts of animosity, enmity, or a cool

indifference, usually at the arrival of one or the other. In this case, inner control of objects is substantiated and displayed externally via the aberrant premise, 'If you *really* do love me, you will even yield to mistreatment as the proof that will satisfy me'; or, 'Even when I am bad you must show acceptance, so that I need not fear rejection under *any* circumstances'. Such relationships clearly comprise a *folie de deux*.

The various mechanisms described above drain the ego of much of its energy. The individual may experience chronic exhaustion and a 'sense of futility', using Fairbairn's terminology. The ego habitually feels a sense of hopelessness in its quest of regaining good objects. Without good objects the ego has no feeling of acceptance, worth, or self-appreciation, nor does it have any testimony that its love is good, and a sentience of inferiority plagues such persons.

IV. PATHOLOGICAL TYPES

The various nosological types of mental illness reflect the ego's largely ineffective methods for dealing with the sadistic ego. These types, e.g. paranoid, manic-depressive, obsessional, take their specific forms from the type of objects that have been internalized (i.e. originally, the parents' characteristic type of responses), the ego's particular relationship with them, and/or secondary ego components split off from the ego in a desperate attempt to eliminate a forbidden wish or guilt-ridden experience. As Freud has commented, a patient may be expected to exhibit symptoms of a variety of neurotic or psychotic configurations. This is explained by the fluid relationships the ego maintains with its different internalized objects and its different defences in dealing with these objects and the sadistic ego.

Before embarking on a discussion of pathological types, I must now present to the reader a fundamental principle concerning the agency and composition of mental illness, but which undoubtedly will encounter the most rigorous of opposition. At this point it may be

unequivocally stated that ALL NON-ORGANIC MENTAL ILLNESS IS PRECIPITATED AND PERPETUATED BY THE SADISTIC EGO. I am certain that many readers will regard such a sweeping statement as an oversimplification, if not as entirely incorrect. I can only respectfully suggest a personal investigation of the matter in the analytic office.

The exposition of the various nosological divisions to follow should be primarily regarded as examples of sadistic ego dynamics rather than a definitive explication of each mental disorder, since each patient's case is a unique, compounded condition regardless of its general classification.

A. *Manic-depressive psychosis*

In the manic-depressive psychosis, the internalized objects represent parents who were not so libidinally rejecting as they were critical, stern, and hyper-moral. Parents of this type continuously scold and admonish the child for what they consider his lack of propriety. He is constantly made to feel guilty, and frequently religious dogma is used to establish his 'wickedness'.

The patient's sadistic ego persistently utilizes the criticizing internalized objects to engender a feeling of guilt. The sadistic ego unremittingly reminds the ego that these objects are evidence that the ego is wicked. Then this adversary points to the discrepancy between the ego's acknowledged badness and what good objects would expect, driving the ego to feel unworthy of its good objects. The result is severe guilt, which more properly may be defined as depression.

In the manic phase, which is a *defence* against the depressive phase, the ego has assumed a 'devil-may-care' attitude. The ego attempts to ignore the sadistic ego's invective of badness by assuming an indifferent and cavalier posture; and a 'so what—who cares?' position is taken as regards the chronic censure from criticizing bad objects. The ego endeavours simply to refuse to assent to dissension with good objects, regardless of the moral or casuistic discrepancy the sadistic ego

seeks to demonstrate. Defensively, the ego goes to the other extreme: the individual exuberantly and often recklessly may act out an 'anything goes' philosophy, a mockery of his chastising objects and travesty of the sadistic ego's indictment. But this flippant and unrestrained expediency eventually succumbs to the efforts of the sadistic ego to re-instate the depressive phase of the cycle.

Hyper-moral parents may also liable an individual to become fixated to a severe, non-manic depressive state. Should such a person become involved in a situation whereby he executes what might be regarded as an immoral or destructive act, the sadistic ego will seize on this incident to drive the ego into an acute and chronic depressive condition.

The problem for the person who has internalized a critical, hyper-moral parent(s) is that the resulting internalized objects may be regarded as good, since they are not libidinally rejecting. As a consequence, the ego is readily subject to guilt (and depression), owing to the inordinately high moral standards that must unfailingly be upheld. Hence, in the depressive psychosis we see a situation in which some of the ego's *good* objects are a detriment to the ego, i.e. they expose the ego, by virtue of their hyper-morality, to accusations of the sadistic ego designed to create guilt and depression. Objects of this type constitute the classical 'stern superego'.

A severe depressive state may easily be confused with schizophrenia. Basically, however, the dynamics are quite different. Libidinally rejecting objects along with tenaciously controlling objects characterize the schizophrene, whereas the depressive psychotic is delineated by an unworthiness to accept his good objects.

B. *Obsessional-compulsion neurosis*

There is a parallel between the depressive psychosis and the obsessional-compulsion neurosis: a forbidden or immoral wish or act that engenders guilt or depression, arising from the resulting discord with good objects. In the individual suffering from an obsessional or compulsive neurosis, as contrasted with the

manic-depressive psychosis, the internalized good objects are not characterized by hyper-morality, and thus the standards necessary to please good objects are not as stringent and the depressive reaction is less severe. To some extent the patient is able to transfer his inner conflict and guilt into a less offensive, conscious rumination of thoughts, ideas, and urges. The factors underlying this type of illness usually centre around a particular external event or episode or a specific wish which, in each case, is destructive or seemingly immoral in nature, and which allows the sadistic ego to drive the ego into contention with its good objects. The external experience frequently involves some type of socially unacceptable sexual incident or a pernicious act. The wish may develop as a consequence of such an experience or may result from an untenable parental relationship: the parent's actions may generate incestual desires; a condescending or belittling attitude toward the child may cause him to develop and harbour a destructive, murderous wish for the parent; a baneful wish toward a brother or sister may arise from the arrival of that sibling if the older child had been libidinally rejected or if parental favouritism develops.

The sadistic ego is not only active in the instigation and perpetuation of mental illness, but it plays a major role in aggravating the tribulation it will later use for endopsychic blackmail. With respect to the obsessional-compulsive neurosis, it is the sadistic ego that will exacerbate the traumatic quality of an external situation, e.g. inflame the ego's hate *vis-à-vis* the offending external object(s) ('Are you going to let them hurt your pride that way?') or cajole the ego into a relationship or type of behaviour having immoral or destructive features ('Do it, or else you've got no guts.'). Once the experience has transpired and the wish has crystallized, the sadistic ego will never let the ego forget it,* as the sadistic ego ceaselessly strives to drive a wedge between the ego and its good objects.

The external acting out (the actual obsessional thoughts or compulsive behaviour) of this nosological type represents a defence against the tyranny of the sadistic ego's menacing incrimination. The defence—expressed as the antithesis of immoral or truculent behaviour—is designed to disprove the sadistic ego's indictment of the ego's transgression, e.g. quasi-love for a person (or a symbolic model) who is hated. The ego tries to demonstrate through its defence that its thoughts or actions make it worthy and deserving of its good objects.

Obsessional or compulsive behaviour serves as a kind of prophylactic aimed at regulation and control of the internal dilemma by a 'magic act' or set of thoughts which are intended to change the scene of action (displacement) as well as to controvert the incessant diabolical charges cast by the sadistic ego.

C. *Paranoia*

The paranoid is an example of an individual whose parent(s) treated him in a condescending and disparaging manner. As a child his actions and behaviour were habitually belittled, usually with some measure of libidinal rejection. The parent was prone to cheapen the child's self-concept with an attitude of scorn and arrogance, which was conveyed to make the child feel abjectly subordinate. In addition, the parents, particularly the mother, may have exerted a controlling influence designed to block emotional and ego development. It is in this regard that paranoia and homosexuality have a common denominator.

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* Here we see a typical illustration of the repetition-compulsion mechanism in operation and the sadistic ego's participation as the propellent force. Where endopsychic blackmail prevails, the sadistic ego incessantly and unmercifully reminds the ego of its forbidden wish, contemplation, or incriminating experience. The obsessional thinking or compulsive acting out reflects the ego's desperate attempt to disprove the indictment by thoughts or behaviour that would exonerate it. In this connexion, it is noteworthy to observe that Freud, writing in *Beyond the Pleasure Principle*, attributed the tenacity of the repetition-compulsion to the influence of the 'death instinct'.

The internalized objects of the paranoid render him highly vulnerable to the sadistic ego's charge that his pride is being offended. The ego is harassed with the following reproach: 'Are you going to tolerate the subordination and derisive manner imposed by those objects?' This plight renders the paranoid very sensitive to the criticisms of other persons, since such comments represent a humiliation owing to the resemblance of internal conditions. Moreover, a criticism is a threat to the paranoid's defence (reaction formation) of 'superiority'. An adverse comment from another person upsets his precarious internal balance, i.e. the sadistic ego immediately illuminates the narcissistic injury that condescending internal objects inflict. In his need to void the accusation of 'humiliated victim', the paranoid defensively reacts with aggression—sometimes verbal or occasionally physical. His defences require instant retribution.* Similar aggression is expressed toward the internalized objects that subordinate him and demand submission. This leads to guilt

* Paranoid and some homosexual patients excessively project condescending internalized objects during the transference, which, of course, causes this type of patient to regard the analyst in that light. This projective process is invariably followed by a series of direct or implied insults or innuendoes directed at the analyst, as the patient's ego attempts to counter derision from the sadistic ego with a defensive, malevolent reaction: 'See, I'm no victim of the condescending objects (the analyst) which try to cheapen me; I vigorously attack them.' This type of patient assiduously strives to make the analyst retort with anger; for it strengthens his defence against the sadistic ego: 'Just look at my triumph and control over condescending objects (the analyst).' This situation develops early in the transference and must be interpreted repeatedly, *beginning with its first occurrence*; otherwise an insurmountable obstacle is created: the patient will no longer be amenable to *any* interpretation, since acceptance of an interpretation becomes tantamount to a narcissistic defeat from the 'enemy' he has fashioned and feels he must conquer and also leaves him vulnerable to the accusation of the sadistic ego that is sure to follow.

and depression since these objects represent parent figures. Where depression is severe and chronic the paranoid illness is superimposed by a depressive and/or obsessional-compulsion condition (i.e. alcoholism).

* * *

The paranoid and criminal type (including many juvenile delinquents) have closely allied backgrounds and endopsychic dynamics. Both have great difficulty in sustaining an internal relationship with good objects, and each has basically a weak and passive ego structure. The apparent rough and tough appearance of the paranoid and criminal type stems from a reaction formation designed to defend the ego against the sadistic ego's accusations of passivity. Both types identify with arrogant and condescending internalized objects, which is exhibited by their behaviour, although the criminal type would seem to embody a goodly number of depraved-oriented objects, particularly of the father. They are both characterized by ideas and phantasy that incorporate megalomania and omnipotence, which, in turn, limit and distort their perspective of reality. Lacking a firm integration of good objects, neither is concerned with morality or social values. In each, the sadistic ego's effort to alienate the ego and its good objects—to reduce the ego to the level of infantile passivity—ignites the violent reactions so typical of this type of individual.

D. *Homosexuality* (*Lesbianism inclusive*)

The homosexual and paranoid both feature internalized objects that condescendingly depreciate and asperse the ego, but the decisive factor that fosters homosexuality is the mother who, usually covertly, demands complete control in her relationship with the child,†

* This section includes a discussion of heterosexuality for purposes of contrast and general elucidation.

† D. D. Jackson of Palo Alto, California, has described the action of guilt from pleasure in schizoid individuals, in his paper 'Guilt and the Control of Pleasure in Schizoid Personalities'. See bibliography.

likewise forbidding any relationships or pleasures that do not include her. Her possessive demand for submission and the suppression of any attempt toward independence prevail on a subtle level of communication. The child soon learns that self-assertion elicits an angry frown or scowl or some signal of badness. Similarly, a submissive reaction meets with a smile, a cue indicating approval, or an expression of selfishly tempered love. The helplessness of the child leaves him no choice but to acquiesce, but covert hatred for the mother and those who symbolize her is apparent in the adult homosexual, with this internal animosity operating as a source of guilt. None the less, the internalized objects of this type of mother preserve their control and demand for submission, and the homosexual's only relationships are with those people who reflect back a similar ('homo') picture of himself.

Turning to the endopsychic scene, homosexuality is the outgrowth and consummation of imposed subjugation whereby the ego must comply with the demands of internalized objects that insist on submission, passivity, and control of the ego. Hence, the ego is forbidden the assertive act of integrating even its good objects (i.e. controlling the relationship) and gaining the ego strength and emotional maturity therein. (The sadistic ego, of course, prevents the ego from defiance of the control demanded by the internalized mother, using guilt as a restraining threat.) Consequently, the homosexual's ego is hardly more advanced in structure than the basic ego of infancy. At this level the homosexual relates primarily with good objects of infancy: the breast-mother, the good breast, and the good paternal penis; and homosexual relations are analogous to a *baby at the breast*, e.g. fellatio. However, a shaky and pestilential semi-amalgamation with domineering and imperious objects renders the homosexual a limited degree of ego strength. This merger is very precariously upheld, and is based on an ironic premise that seemingly thwarts contradiction from the sadistic ego: the ego takes the position, 'It is

permissible for me to relate and identify with arrogant and dominating objects of mother because it allows me to emulate and be like her, which would please her. Anyhow, an evil identification makes me as wicked and malevolent as you. We are now allies!' This mechanism is also observed in some paranoid individuals.

The homosexual, as with the paranoid, is under constant pressure regarding the condescending and controlling objects in his personality. The sadistic ego unremittingly taunts, 'Why do you let those objects cheapen and subordinate you? Have you no pride?' The homosexual meets this accusation with a defence similar to that of the paranoid. By identifying with arrogant, domineering objects that he has internalized, he struggles to strengthen his ego with a 'superiority' attitude; and, homologous with paranoia, homosexuality is marked by varying degrees of delusions of grandeur.

Clearly, the homosexual is committed to a network of defences—*but even his sexual pleasure is a form of defence*. It is an ironic and somewhat revengeful mockery of subordinating and controlling objects: by purposely submitting, *as an infant*, to the libidinally charged objects of infancy, he is able to gain sexual pleasure from the enforced submission that is demanded of him. Thus he ridicules subjugating and controlling objects by making a pleasurable travesty of submission. Unfortunately this indirect vindictiveness toward parental objects induces depression, a characteristic symptom of homosexuality.

The lack of an integrated and firm identification with good objects and the virtuous and moral elements they embrace accounts for the homosexual's contempt for social principles and ethics. As with any schizoid, he desires a close and unified relationship with good objects, but his inability to achieve same leaves him to feel cheated and, therefore, entitled to flout the standards of a society from which he feels alienated. Similar to the ironic mockery he displays for domineering, controlling objects, the homosexual—with 'sour grapes'

compensation—takes delight in brazenly making a burlesque out of social morality.

*   *   *

The study of homosexuality assumes considerable importance for the reason that it provides an understanding of the dynamics underlying *heterosexuality*. As previously stated in this paper, heterosexual love is based on the projection of all the good objects of infancy and childhood onto another person, which, of course, is contingent on a unified and secure union of the ego with these objects. The healthy individual, by definition, has a close relationship with his internalized good objects, as manifest by the libido available to his general ego expressions, and to some extent he projects good objects in all his external relations. However, the large-scale projection of good objects, *particularly the highly libidinally fused objects of infancy*, will be heterosexually directed owing to several reasons.

When good objects are projected onto another individual, there is the concurrent need to regain them, and this, of course, necessitates the introjection (with internalization) of the external object onto whom they have been projected—and who consequently has become idealized, representing the best of the lover's own personality.* As germane to this subject, we must consider that the ego's relationship with good objects, which characterizes the healthy individual, promotes (and gives substance to) a favourable self-concept and body image, a wholesome 'narcism'; and the body image is consistent with his actual anatomy since *reality*† (cf. Freudian 'Reality

Principle') is a consequence and property of the strong, integrated ego of the healthy person. Thus to introject and internalize a member of the *same* sex would undermine and subvert the body image and self-concept; for such an internalization represents a willingness to vitiate the body image of the self by the incorporation of another person of the same sex, whereas large-scale projection of good objects onto a person of the opposite sex—the sensation of self-abandonment—can be safely accomplished, since introjection and internalization of this person does not involve replacement, supersession, or undermining of one's own body image and the consequential injury to the self-concept, i.e. there is not a depreciation of one's own body image and self-concept as would be the case if a comparative type were internalized. A heterosexual person does not rival the body image and self-concept but may complement or enhance it in a manner reminiscent of the Greek mythology figure Hermaphroditus.

In the heterosexual, libidinal sensations are interpreted through the body image, which, as stated, is based on the actual anatomy of the individual, and therefore are acted out through that anatomy. This prevalence of reality obviously brings an objective appreciation of one's own genitals and the biological compatibility of heterosexuality; correspondingly, affective, erotic stimulation is translated in terms of one's genitals—and their apt relation to the genitals of the opposite sex. In brief, *the heterosexual individual evinces a congruity between the psyche and the body.**

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* This process of projection and introjection has the effect of greatly intensifying the ego's relationship and union with good objects and heightening the degree of libido experienced by the ego.

† Reality perspective is a property of the ego that maintains a secure, sustained integration of good objects, since these objects provide a strength and posture that allows for successful *inner* organization, thus providing the foundation for establishing and directing orientation to the

outer world. In contrast, internal disorder requires that the weakened, crippled ego maintain continuous surveillance over precarious inner processes, a situation which gives rise to a schizoid, sharply *introverted*, and immature personality. As a result the ego's magnitude is substantially minimized, impairing ego-identity and objectivity.

* The unconscious ego, as with the Freudian Id, is devoid of an appreciation of reality. At a *pre-conscious* level there is a fusion and blending of the body image (from the conscious ego) with internalized objects (from the unconscious ego),

The healthy individual's integration of good objects encompasses two other factors propelling him in the direction of heterosexuality. First, a relationship with good objects (super-ego) commits the individual to follow the mores of society inasmuch as he is subject to a reprimand from good objects (i.e. guilt) should he violate the standards of society. And society, of course, condemns homosexuality, whereas heterosexuality is not only supported but demanded. Secondly, the weak and infantile structure of the homosexual's

especially during libidinal ascendancy. At this level various parts of the body are effectively construed as permeated by part or whole good objects. Thus, for example, the penis may convey the undifferentiated sensation of the good breast; the bust and arms may likewise provide the indistinct sensation of the good mother of infancy, particularly as she tenderly holds her baby. Lovers readily confirm this point: the desire to tenderly hold or to be held, a characteristic of both sexes, is part and parcel of heterosexual love.

* This contrast in ego development between the heterosexual and the homosexual is not intended to infer, as in classical psychoanalytical theory, libidinal fixation to an erotogenic zone, such as the oral, anal, and genital. As with Fairbairn, I can no longer find this venerated Freudian cornerstone (advanced by Abraham) as serviceable. As the reader has undoubtedly surmised, in my view ego and psycho-sexual development is contingent on the ego's ability to successfully maintain a sustained and unified relationship with its internalized good objects. This coalescence strengthens the ego, affording a reality that imparts uniformity of the body image with the body itself; and the ego has available good objects, which it can project (and re-introject) for the process of erotic expression (or simply put: to love). Childhood experiences may, indeed, establish a libidinal predilection for any bodily zone, but this is a secondary, *independent* result, separate from genital, heterosexual development. The oral, anal, and genital phases do not represent order of progression of *libido* but rather the order that these biological phases, regardless of the libido factor, are most active in the *chronological* maturation of the individual's body. Libido does not lead but *follows* physical-'zonal' development.

ego is intuitively sensed by heterosexual persons, and the fear of having his own ego degenerate to that level repels the heterosexual from possible sexual relations with the homosexual. *

The factors, as discussed above, which direct an individual toward heterosexuality do not influence the homosexual since they are predicated on the individual's having a firm, consistent integration of good internalized objects. This, of course, does not exemplify the homosexual—who makes no attempt to regain his good objects and who is forbidden to assert the process of establishing a relationship with them.

E. *Melancholia*

Attenuated manic-depressive elements underlie the illness of melancholia. This condition, however, is usually dormant, and satisfactory external relations give ego support to the potential melancholiac and allow him to act out the reparation that sufficiently cancels the guilt and depression which the sadistic ego seeks to generate. A satisfactory relationship with his spouse and other loved persons sufficiently stimulates rapport with his internalized good objects and reassures him that he is worthy of them.

The potential melancholiac is usually a very accommodating, solicitous, and forgiving individual; for he is motivated by the need to make reparation and the fear that his 'wickedness' or a destructive animus may injure or incur the wrath of his loved ones. As long as the *status quo* prevails, this type of person is able to successfully check his sadistic ego and the latter's efforts to promote disunity between the ego and its good objects. But the delicate internal balance is crucially dependent on the state of external conditions. The death of his mate or some other loved person often proves to be devastating.

The loss of a loved one, particularly his spouse, brings the melancholic features to the fore. The sadistic ego tortures the ego with the charge that the latter's wickedness or hate has destroyed the external object and the internal

good objects which it represents. No longer does the ego have the external object which activated internal counterparts, nor can the individual act-out the restoration that mitigated and allayed his guilt. The loss of an external object also gives the sadistic ego an opportunity to reactivate the depressive position of infancy, which Melanie Klein has so accurately described, and the ego suffers a repetition of the grief that transpired during that early period.

Melancholia is generally regarded as a geriatric problem. This is not surprising inasmuch as the events that precipitate this condition are likely to occur in an individual's later years. The death of one's mate may take place during that time, and the melancholiac's children are likely grown and living apart from him. In addition, friends and relatives may have moved to other locations or become deceased. Without the people who furnished support for his ego, the melancholiac finds it increasingly difficult to check the depressive components of his unconscious. This depressive condition frequently triggers thoughts of his own death. Feeling unworthy of his internalized good objects, he does not feel worthy to live.

F. Alcoholism

While alcoholism is an affliction that encompasses a wide gamut of pathological forms, it would seem to this writer that there is a decided preponderance favouring the paranoid syndrome. The pharmaceutical effects on the cortical and subcortical areas of the brain are complex and largely undefined, but undoubtedly resulting variations in the degree and proportion of libido and aggression energy reaching the cerebral-psychic level are a related function and account for the alcoholic's broad behaviour transitions* as he engages in a drinking episode.

He may act *kindly*—a defence against a murderous wish for a parent: 'See how good and benign I am.' He may act *aggressively*, as the sadistic ego ridicules his subordination to disparaging and controlling objects—a defence against humiliation and passivity. He may act *depressed* and *morose*, as the sadistic ego accentuates his destructive wish for the parent. In this latter case self-punishment and self-destruction are efforts at redemption by damaging *himself* (with alcohol), as he desperately strives to expiate his endopsychic iniquity; his defence reads: 'I want to destroy *myself*, *not* mother/father.' The '*dead* drunk' stage is a poignant illustration of this operation in the alcoholic's drinking proclivity.

In addition to the factors discussed above, self-destruction entails another, compounded process in the alcoholic syndrome. By injuring himself, the alcoholic can assert an *active*, ironic, and indirectly revengeful rebellion to the *passivity* imposed by subjugating and/or controlling objects. Via this pernicious form of drinking the alcoholic is saying to these objects, 'At least in this matter your power over me cannot prevent *my* resolution— of *self*-destruction'. However, beneath this prolonged form of suicide, at the deepest level, lies an agonizing plea to bad objects and to good objects with which he seeks unification, i.e. to maternal objects generally: 'Please love me instead of subjecting me to humiliation and passivity. If you don't change, I'll [eventually] destroy myself (with alcohol); then you'll be sorry.' The alcoholic's megalomaniacal and aggression defences serve as a façade of this deeper need. In essence, alcoholism represents a series of compulsive defences.

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* On the subcortical level alcoholic beverages apparently have some of the properties of the psycho-pharmaceuticals, especially on the reticular activating system. Depending on quantity and duration, alcohol simulates the phenothiazine tranquilizers by reducing the effect of cerebral-psychic stimuli evoking aggression energy: initially, a state of relaxation; later, narcosis. And it approximates the anti-depressants (or 'psychic energisers') by lowering the threshold for stimuli evoking libido: initially, a 'happy' feeling; later, uninhibited hilarity or belligerence. Specific variations, of course, are dictated by each individual's particular psychological make-up.

G. *Schizophrenia*

To augment the general discussion dealing with schizophrenia and allied modality, in the section 'The Schizoid Nucleus', some specific remarks on this topic follow.

Recent psychiatric publications have emphasized a learning theory approach for an explication of schizophrenic etiology. Authors of these articles envision the child as exposed to contradictory, conflicting, and confusing verbal and non-verbal cues. It is suggested that stimuli input cannot be assimilated, producing a kind of 'short circuiting' of psychological processes. Undoubtedly such a deleterious mode of parental behaviour correctly *describes* the pathological conditions that subtly pervade the parent–child relationship, but what of the active dynamics that constitute the *perpetuation* of the schizophrenic *illness*? If we define illness as encompassing pain, suffering, and discomfort, we must assume a driving agent, i.e. an energy factor, as the operating *source* and *sustaining* component in the mechanism of a condition as severe and profound as schizophrenia.

The variety of noxious stimuli which some behaviourists contend are responsible for schizophrenia have their significance when considered in terms of a Gestalt: detrimental stimuli are viewed as hostility or debasing/stifling control* emanating from the *whole* object—which is introjected and internalized. In the schizophrenogenic setting contradictory and conflicting stimuli apparently comprise an extraordinarily effective means for hypercontrol over the child: he is made to feel confused so that the mother, in particular, can covertly convey to him that he is too *helpless* to think for himself (cf. garbled speech), and the corresponding internalized objects are controlling to the extent that they forbid his ego to differentiate itself from her. Good objects

* The type of control modifies the schizophrenic state: debasing: paranoid; stifling: catatonic. The hebephrenic reaction denotes a pathetic, quasi-manic defence against hostile, inculpating accusations from the internalized objects of the mother.

dared not be integrated—this would be disobedience—and the destined schizophrene is even denied the right to exercise ownership of his own body. Such a mother tends to regard the child more as a commodity rather than as another human being. Suffice to say, the sadistic ego is an active participant on the endopsychic level once this baneful-type mother has become extensively internalized. It is worth reiterating, however, that bad objects *per se* do not effect the ego's downfall, i.e. as an *isolated* group the ego could readily manage them via repression; it is only in so far as bad objects serve as endopsychic blackmail for the virulent motives and action of the sadistic ego that they damn the ego.

In observing the plight and behaviour of the deteriorated, adult schizophrene, we see a situation in which all defences for combating the sadistic ego have proved inadequate and the ego is reduced to the basic skeletal-form of infancy. The ego is completely deprived of its good objects and the important identification and structuring they ordinarily render, and the sadistic ego periodically breaks into the ego's conscious field, which accounts for the wild and violent eruptions that occasionally mark this type of illness. Bad objects are not repressed to any measurable extent, and they move into consciousness where they are manifest as delusions, hallucinations, and the hearing of voices. The incoherent speech of the schizophrene is a manifestation of the ego's uncontrolled, subjugated relation to these objects, which intermittently flood the ego with an excess of affective discharge, e.g. inappropriate laughing and giggling displayed by the hebephrenic.

The specific dynamics involved in the impasse confronting the schizophrene are described in the first mechanism outlined in 'The Schizoid Nucleus'.

V. STATES OF SENSATION

A. *Anxiety*

Of all the complaints and disturbances that mentally ill patients present, none is so common as anxiety; for this symptom is a feature

of a majority of nosological types. While many explanations have been offered to shed light on this problem, in this writer's judgement anxiety can only be dynamically understood in terms of the sadistic ego.

Anxiety denotes a concerted attack by the sadistic ego on the ego, utilizing inner blackmail in combination with the ego's dread and fear of the impending loss of good objects as the focal point for the attack. The sadistic ego is charged with aggression energy, and it has the capacity to impose a formidable threat to the ego when endopsychic conditions serve to weaken the position of the ego. Intimidated by the possible loss of good objects, the ego dares not retaliate with aggression energy. Rather, the ego hopes to appease the sadistic ego by conceding to the latter's voracity for inflicting pain and anguish; *thus the ego elects to yield to the sadistic ego's assault* but within limitation which is felt as *anxiety*. Hence, anxiety is a kind of 'deal' in which the ego endures suffering as the price for not being forced to relinquish its good objects.

The usual, descriptive approach used to explicate anxiety provides no real understanding of the difficulties facing the ego. Such severe reactions as trembling, fright, excessive perspiration, acute restlessness, cardiac palpitation, etc., obviously imply a force with which the ego cannot cope. If one attempts to explain anxiety without consideration of a powerful, *auto-dynamic* force, the extreme mental and physical reactions of the individual are meaningless. Even 'beyond the pleasure principle' there is no logical rationale as to why the ego should persecute and injure *itself* indeed, *by itself* which is the stock, tacit premise underlying virtually all psychological theories.

B. *Sadism and masochism*

Often the terms sadism and masochism are joined, forming the expression 'sado-masochism'. This implies the two are functionally allied, and investigation of endopsychic, structural dynamics confirms the connexion.

Two factors are common to sadism and masochism. (1) An acrimonious disposition engendered by the ego's frustration and exasperation that is fermented by the fruitless effort to escape infantile impuissance. (2) The presence of cruel, rejecting, and in many cases, subjugating objects in the personality. The ego's particular type of relationship with these objects is the variable that determines the sadistic or masochistic direction.

Both sadism and masochism are a defence against the sadistic ego's accusation that the ego is the helpless, emasculated victim of cruel, rejecting objects, ostensibly proving the ego's love is bad. This is a decided threat to the ego's megalomaniacal defence (see footnote, p. 182). To assuage its wounded pride the ego may resort to one of two defences aimed at resuscitating its megalomania. The ego may elect to identify with the cruel, rejecting object, transferring to it a perverse and destructive *power* over *all* internalized objects, especially the highly libidinally charged objects of infancy which are seized for the erotic pleasure they render. This appropriation of power re-establishes the ego's megalomaniacal defence; and the total sensation when acted out constitutes *sadism* pleasure in hate. The sadist's philosophy is primarily a sardonic message to the internalized mother: 'Since you will not give me the pleasure of love, I will force you to, at least, provide me with pleasure in hate.'

On the other hand, the ego, when confronted with the dilemma described above, may resort to a defence reminiscent of the homosexual's technique for preserving his megalomania. In the masochistic operation the ego passively *invites* cruel, rejecting objects to hurt it, i.e. it submissively releases its repression of them. The ego plays a dangerous game of mockery. When asked to verbalize his sensation of masochism, one patient reported the intrapsychic drama as follows: 'The more they (cruel objects) *smash* me, the more I *like* it. They push me more and more to feel delightfully helpless as a baby. The pleasure increases the further "down"

I go.' The patient affirmed that this pleasure was the product of a more intense relationship with infancy objects, remarking that these objects seemed to be enveloping him. Hence, *masochism*. As with sadism, this perversion affords a contorted method for the restoration of megalomania. The masochist's philosophy is also a vitriolic message to the internalized mother: 'Since you will not give me the pleasure of love, I will make a joke of your cruelty by manipulating you into at least providing me pleasure from pain.'

A specific propensity for either sadism or masochism likely depends on the extent to which controlling, subjugating objects have also been internalized: the more prevalent they are, the greater the proclivity for masochism.

Sadism and masochism represent bizarre methods for preserving megalomania, a necessarily exaggerated appreciation by the ego of its libido; and they must be viewed as morbid *defences* designed to maintain some minimum measure of assurance for the schizoid that his love has worth. Neither sadism nor masochism should be regarded as an end in itself.

Sadistic or masochistic reactions may be triggered by an external stimuli symbolizing or associated with a particular traumatic experience. Hence, sadism or masochism may represent a compulsive defence (quasi-conditioning) if the ego invariably chooses the same perversion to function as its crutch.

C. *Depression*

As has been discussed under the section 'The ego-ideal', guilt is a product of the ego's exigent request for admonishment from its good objects, necessitated by the fear, as promoted by the sadistic ego, that an ego action or forbidden wish has made the ego unworthy of retaining its good objects. If the individual's alleged immoral offence is sufficiently great, guilt will be so prolonged and intense as to constitute *depression*. (Nevertheless, the actual *operation* and process of disharmony (guilt or depression) must ulti-

mately be ascribed entirely to the executive capacity of the highly organised, autonomous ego, even though the ego *adjudges* and regards the aggression-laden rebuke as a faculty of good objects.)

A feeling of guilt is certainly not an extremely rare sensation for any individual to experience at one time or another, and even a healthy individual may be subject to fleeting depression, since misfortune or adversity is an inevitable part of life. However, a single experience having pronounced immoral, offensive, or desolating features may evoke a very sudden and severe depressive reaction, depending on what depression-inducing components already exist. Unlike the schizoid condition, which develops progressively, a sharp attack of depression leaves the individual no opportunity to prepare defences. The experience may prove overwhelming, and the individual may even be driven to commit suicide, despite the fact that he generally had functioned with a vigorous, extrovert disposition.

D. *Shame*

The sensation of shame is related to the mechanism of guilt in so far as the sadistic ego seeks to establish a discrepancy between an ego action and what good objects would condone. In regard to shame, however, the action of the individual was not strictly immoral, rather it represented selfishness, nescience or ineptness, and usually was not premeditated. Hence, the sadistic ego is only able to demonstrate the individual's lack of propriety or the inappropriateness of the action, and the ego can usually plead ignorance, the all-forgiving excuse. Thus the ego feels justified that a minor violation requires a less vindictive reproach from good objects to expiate the infraction, and the ego is less fearful that the incident will cost it the price of discord with good objects.

E. *Grief*

At the death of a loved one the sadistic ego plagues the ego with the assertion that all internalized good objects have been lost for

ever. Any destructive components from the earlier years, such as from the 'depressive position' of infancy, are insidiously illuminated and reactivated as the sadistic ego attempts to inculpate the ego for the loss of the external object and its internal counterparts. During a state of grief the ego feels utterly poverty-stricken. The excruciating agony that is experienced in this period arises from the sensation of devastating isolation. In addition, there is the subsequent feeling, imposed by the sadistic ego, that with no remaining good objects to love and bolster the ego, the latter is forever worthless and inexorably wicked.

Recognition that grief involves isolation from good objects affords substance to the generally acknowledged philosophic observation that we really grieve for our own personal loss and not actually for the deceased himself.

VI. 'DEATH INSTINCT': CEREBRAL DEVELOPMENT

Even though willing to concede that the unconscious territory of the human psyche contains many uncharted, unknown, and enigmatic constituents, many readers will regard the theme comprising the sadistic ego theory as too implausible to accept. Yet, it would seem to this writer that the formulation of the sadistic ego concept is no more eccentric or bizarre than the 'death instinct' hypothesis, which it has recast and accordingly proposes to succeed *suo jure*. Be that as it may, it is certainly noteworthy that Freud's writings abundantly hint that the death instinct evinces a more organized and purpose-directed nature than what might ordinarily be attributed to an instinct (see footnotes, pp. 178, 185), and he even considered it expedient to personify this phenomenon with the term 'Thanatos'. As with Freud's discovery of the unconscious, the death instinct hypothesis offended the conscious ideals of humanity and it encountered much resistance even among some of his most devoted adherents; so much so that Freud himself became equivocal as to its validity.

(In the United States today it is generally neglected or disregarded.) However, the great value in much of his work lies in its enormous *potential* for further investigation, as Melanie Klein has so admirably demonstrated.

In this writer's judgement an endopsychic destructive influence that is viewed as a sub-ego structure lends itself more readily to the biological sciences and their orientation *au courant*; accordingly, it would be difficult to accept a literal death instinct thesis. In as much as an instinct is a rather significant aspect of an animal, it obviously requires a long string of mutations, covering many preceding species, before it fully evolves. The study of evolution discloses the fact that a weak or degenerate morphological development in a species leads to that species' extinction. Therefore, it logically follows that the homo sapiens never could have evolved, in the first place, for his predecessors carrying such an instinct would have succumbed to extinction long before the phylogeny culminating in the appearance of man. Perhaps there is some compensation to be derived from the consideration that man's manifestations of self-destruction are the consequence of his interchange with his post-natal environment rather than something that is as biologically innate as an instinct.

While aggression energy has taken a diverse and perverse route in the human psyche, its emergence in the course of biological evolution was prompted for the purpose of complementing libido, the reproduction energy, for the purpose of propagation. Aggression energy, in its most basic, primitive form, may be regarded primarily as a psychic motor stimulus intended to activate the muscular system for combat. It serves libido by allowing the primitive organism the opportunity to survive long enough to procreate and protect its offspring. The homo sapiens appears to be the first mammal in which aggression energy, via the sadistic ego and internalized bad objects, acts as a detriment to both the individual and the species variety to which he belongs.

In man we see a plight of the first magnitude.

Each individual—and thus the race collectively —is faced with the paradox of finding that one of his own tools for self-preservation, aggression energy, is usurped and redirected and then discharged back onto himself. Man's nervous system and ego is highly refined and sensitive: so sensitive that the ego is susceptible to the mechanism of splitting—under varying circumstances. The secondary egos that result from this splitting may be 'enemies' or 'friends'; but those that are alien to the ego (particularly the highly organized sadistic ego) have the capacity to propel aggression energy *against* the ego, *making man a biological freak*. The splitting mechanism as a defence all too frequently boomerangs. (Beneficial splitting occurs, of course, when good, loving objects are internalized, creating 'channels' for routing *libido* to the ego.)

The human being's advanced cerebral cortex has allowed for an intelligence that provides him with the flexibility to counteract the encroachment of other organisms that might attempt to supersede man as the dominant form of life (e.g. some biologists maintain that if man did not have the capacity to invent insecticides the insect would over-run him on the strength of number). In addition, the human being's intellect has, of course, made it possible for him to make great scientific discoveries, especially in the fields of nuclear physics and chemistry. But the intelligence necessary for such discoveries and innovations emanates from the same cerebral development that generates an ego which is subject to the mechanism of splitting. When ego splitting represents a mis-channelling of aggression energy, we see a situation where man's ascended nervous system is both an advantage and a disadvantage. But since the detrimental components lie hidden in his unconscious, the advantage (his intellect) can be perverted by these powerful, destructive forces of which man is unaware and, therefore cannot control, with special reference to the sadistic ego. What could surpass the irony of man's *intellect* serving as the tool for his own destruction and evolutionary demise?

VII. Notes on the sadistic ego; war

I think it would be useful to make a delineation between the sadistic ego and the Freudian superego.

As is well known, Freud viewed the superego as evolving at the decline of the Oedipus complex and concluded that the superego represents an internalization of the parents' authority over the child. The sadistic ego, on the other hand, evolves out of the earliest months of infancy. While the Kleinians have extended the *genesis* of the superego to the infancy level, they consider the superego as a composite of the *years* preceding the decline of the Oedipus complex. Tangentially, I regard the inclusion of bad objects to the superego constellation, as advanced by a majority of the Kleinian group, as inconsistent with and a vitiation of Freud's intended guilt-function for these components.

In either the Freudian or Kleinian position, the superego is dependent on environmental and phantasmal variables for its development; thus the superego may take a course of many forms and features among different individuals, with cultural and ethnic factors having a decisive influence. The sadistic ego, in contrast, is the product of a basic and inescapable conflict of the post-natal period of the homo sapiens: cognative powers that frustrate the infant's attempt libidinally to cathex an object.

In Freudian theory, opposition to the superego culminates in guilt, although I am uncertain if Freud meant this guilt was *inflicted* by the superego or if the superego's censure impelled the ego to impose guilt upon itself. (As previously stated ['The ego-ideal' and 'Depression'], it is my judgement that good objects act as the superego—including a contingent capacity to inflict aggression energy— whenever the sadistic ego is able to show a discrepancy between an ego action or proclivity and the standards of good objects.) In any case, the unequivocal difference between the sadistic ego and the Freudian superego is function: the sadistic ego seeks to torture the ego; the superego induces guilt when immoral

or anti-social behaviour is manifest or contemplated in the form of repressed desires.

Some psychoanalysts speak of a flexible, compromising superego, one which becomes more lenient through analysis or which can be altered in its composition. Conversely, the sadistic ego is inexorably dedicated to the destruction of the ego.*

*   *   *

The general theory presented in this paper is by no means an isolated, tightly circumscribed approach to behavioural understanding. On the contrary, the theory represents a confluence of the following: (1) Freud's essentially biological conception. (2) The chemo-anatomical route, currently gaining momentum. (3) A purely psychological (mental) viewpoint. The psychological level of the theory stresses the formation of secondary ego structures, ranging from the highly organized sadistic ego to the weakly organized bad and good objects. The significance of this schema centres around the fact that *ego* structures embody the property eligible to stimulate the production of biological forces, namely, libido and aggression energy, at the subcortical level. (The reader has undoubtedly noticed the term 'aggression' has been subordinated to the function of an adjective—grammatical considerations notwithstanding—for the purpose of emphasizing the energy factor.) From a biological perspective, mental illness can be viewed as a profusion of aggression energy which has flooded and impaired the mental processes.

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* However, analytical insight provides the patient's ego with considerable control for dealing with this internal tormentor, and it would seem that progressive reprisal in the form of aggressive retaliation tends to deter the sadistic ego. The ego's proportion of strength is greatly increased simply by the conscious awareness of its adversary, and the ego's additional striking force serves to complement its sophistication for avoiding the pitfalls to which it was previously liable. Securing these gains is fundamental to successful analytic therapy, in this writer's opinion.

Where the sadistic ego's affect on the ego is limited by a paucity of endopsychic blackmail, the former may indirectly and unwittingly serve some useful purpose for the latter by way of its campaign of torment. Through its incessant accusations of 'inadequacy', 'incompetence', 'mediocrity', and general inferiority, the sadistic ego is able to induce just enough discontent to motivate the individual toward a constructive 'defence': to refute the sadistic ego's charges, the individual is stimulated towards the attainment of goals and achievements he might otherwise not seek. Hence, the feeling of satisfaction from an accomplishment—the sadistic ego has been disproven and silenced!

While a state of worry illustrates the sadistic ego's most extensive and repetitive type of weapons, as well as effectuating a drain on the ego's vitality, to some extent worry can be of benefit, such as when it impels the individual to consult a physician at the sign of illness, to take safety precautions for certain activities, to alter or flee from objectionable or hazardous conditions, etc. Of course the sadistic ego acts as a decided detriment when worry fuses into anxiety and panic, as manifest by hypochondria, an endless test or inordinate use of safety devices, complaints of persecution, etc.

Finally, the sadistic ego's participation in the endopsychic drama sets the 'stage' for the productions of the novelist, the artist, the actor, the philosopher and many others, all of whom are, basically, externalizing (via sublimation) the ego's relationship with the sadistic ego and internalized objects.

*   *   *

True, the sadistic ego may obliquely yield a few useful by-products; however, when we consider such phenomena as the diverse manifestations of mental illness (including the alarming pervasiveness of psychosomatic conditions), related problems such as crime and drug addiction, and most importantly, the incidence of war, it is arrestingly clear that man is generally incapable of dealing with the intrapsychic aggression that is usurped and subversively directed towards his aggregate ego.

The sadistic ego surely has no parallel as the great scourge of mankind. *

Examination of the contemporary scene makes it painfully apparent that this psychic scourge is approaching monstrous proportions. The physical sciences, with centuries of background from which to draw, have outstripped the behavioural sciences, and as a consequence there exists a perilous disparity between man's capability to devise hideous methods for mass destruction and his profound ignorance of the unconscious, emotional factors that temper his conscious motives for such action. It would certainly seem that humanity has reached a decisively critical point in its history. The universal proclivity for destruction that has guided man into war since time immemorial has steadily consolidated with the physical sciences to a degree just short of the 'point of *no* "return"'!

History furnishes more than ample confirmation that war is about as probable and predictable as a patient's repetition-compulsion behaviour—and could even be analysed in terms of that mechanism. International negotiations provide, at best, a temporary stalemate, which may create an illusion of peace but of short duration. The conference table, where *conscious* rationale is the means for settling dissension, affords virtually no practical value inasmuch as war furnishes a 'necessary' avenue for an *unconscious* requirement which pre-empts and ultimately decides the issue. A contentious proclivity, fostered by a perpetual and frustrating battle with the

sadistic ego, compels man to *act out* this endopsychic conflict, which is interpreted on the conscious level as a need to aggress and subdue an external representative of his *inner* adversary. Thus one enemy is substituted for another.

The eruption of war arises from a malignant circle of factors in which each actuates one or more additional factors but with no clear-cut starting point. For example: An encroachment or infraction perpetrated by one nation tends to establish it as a likely target onto which the collective sadistic ego will be avidly projected by the offended nation: 'We'll give 'em trouble if that's what they want.' The violation permits a quasi-moral excuse for 'righteous' enmity, and the offending nation becomes symbolic of a force which must be opposed, repressed, and controlled. Abetting this process is the taunting influence of the sadistic ego, which dichotomizes the alternatives of action: 'Will your *pride* allow you to tolerate this abuse, *or* do you prefer to be a "humiliated victim"?' This is an especially trenchant charge since the rival nation is a surrogate of the sadistic ego and this affront has the effect of a challenge. The altercation becomes more serious and gains added vindictive momentum as each nation's threatened pride incites it to do its adversary 'one better' and because each nation increasingly reflects the sadistic ego, as the operation of mutual projection is intensified. Animosity may wax and wane owing to a variety of additional factors, but a retrospective analysis will verify that military action marks the eventual outcome of acrimonious relations.

It is certainly biting irony that civilization itself tends to accentuate man's predilection for aggression. The inhabitants of backward, primitive lands must expend most of their energy fighting for survival against the enemies supplied by nature: disease, starvation, inadequate shelter against climatic conditions, etc. Having conquered a majority of these adverse natural elements, civilized man has time and facility to direct his penchant for aggression against his fellow man. The need to deny the unremitting sadistic ego accusations

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* At the risk of appearing to simulate a page from Aldous Huxley's novel *Brave New World*, it is this writer's most serious and sober conviction, based primarily on clinical observation, that the future of a civilized, viable humanity in the nuclear age hinges on a new and radical approach to the treatment of the infant during the first half of his initial year. What specific modifications are necessary to attenuate, if not preclude, the formation of the sadistic ego is, of course, a matter for subsequent investigation. Perhaps the rapid development of psycho-pharmaceuticals may eventually provide a practical answer.

of inadequacy or inferiority promotes a compulsion for *power* and the ego defence of *greed*—the desire to rape another nation; the latter serving as a scapegoat. The political, economic, ideological, social, or religious issues compiled by historians to elucidate the multitude of blood-spilling conflicts of this planet fail to explain or illuminate the unconscious factors nurturing these diverse, conscious rationalizations for aggression.

The question will surely be raised, why must this belligerent acting out necessarily transpire in a framework of war? Of course neurotic or psychotic individuals, whose endopsychic situation is more compelling, manifest aggression towards family, friends, nationality or racial groups, and in the form of crime; however, this is not a satisfactory outlet for the majority of persons. Destructive feelings or behaviour directed at one's family, friends, or society (representatives of good objects) engender guilt! As an 'attractive alternative' war is adaptational and seemingly preservative: it is so much more advantageous to fight strangers, an abstract enemy, than family or friends.* Indeed, war even provides a paradoxical morality for expressing enmity. Is not one furthering a cause that is supported by all of one's countrymen?

* It is interesting to observe that a much greater degree of harmony, consonance, and cooperation prevails *within* a nation when it is at war. A uniform, common target for aggression has been established.

It might be argued that there are nations that do not want war, and reference could be made to the fear of nations facing pending danger in current world affairs. However, if the acting out of aggression represents an unconscious need to subdue the sadistic ego, an individual or, collectively, a nation must find a surrogate for the sadistic ego that is surmountable and likely to succumb to defeat, which in fact has largely characterized the history of today's less powerful countries. Hence, the strategy is calculated to aggress a weaker nation or one which is no more than relatively equal in strength. It is true, of course, that nuclear weapons, with their cataclysmic implications, have tended to impede an accurate assessment of strength and retaliatory capacity among various nations, as well as for the most propitious time to strike. None the less, the principle remains the same, and only a definitive change in the present balance of power is required for the pent-up lust for aggression to manifest itself.

Consciously, man claims to abhor war, but unfortunately the record does not coincide with what he utters; and herein lies the disparity between the conscious and unconscious levels. Considered from a psychoanalytic viewpoint, war is the personification of folly: for the individual is essentially struggling to win an internal battle through a medium that serves only to inflict external misery. Isn't it long past the time that we get off this ravaging carousel?

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Reviews

An Evaluation of the Bender–Gestalt Test. By
A. TOLOR and H. C. SCHULBERG. ($9.50.)
Illinois: Charles C. Thomas.

In this comprehensive review of the literature
published before 1961, on the Bender–Gestalt Test,
the authors have done a valuable service for both
clinicians and researchers alike. It is a critical
survey which gives a good assessment of the
current status of the test.

Lauretta Bender, in the foreword, states that she
feels that much of the research with the test was
disappointing because the concepts of Gestalt
Psychology and the maturational features she had
emphasized had been neglected. She therefore
makes a statement of her current views on these
points.

The authors themselves agree that much of the
research has been concerned with low level con-
ceptualizations and they make a plea for a theo-
retical analysis '...which would clarify exactly
what the test measures and how it does so'. The
material is organized around the independent
variables of age, sex, personality, culture, psychi-
atric diagnosis, physical treatment and intelligence.

The deficiencies of different approaches are
stated impartially. On the one hand are the
excesses of subjective interpretations which are
not adequately validated. On the other is the arid
objectivization exemplified by the research which
produced a scoring technique requiring 15 hr. to
complete one protocol.

However, the authors aim to be constructive in
their criticism and indicate the fertile ground
which research should cultivate as well as the
ground which has proved barren.

<div style="text-align: right">C. E. GATHERCOLE</div>

Medizinische Psychologie (Medical Psycho-
logy). By ERNST KRETSCHMER. (Pp. 401.
DM 37.) 12th revised Edition. Stuttgart:
Georg Thieme Verlag. 1963.

This book, which appeared for the first time in
1922, owes its popularity to the author's eclecti-
cism and his ability to keep it up-to-date. It is not
addressed to the psychiatrist but to the medical
student, the general practitioner and to the
psychologist. The author endeavours to relate
mental processes to brain functions wherever
possible. His attitude to psychodynamics is posi-
tive although he rejects the concept of the uncon-
scious and prefers Schilder's notion of the
'sphere'. Ethology is given a good deal of space.
The book is likely to continue to occupy a unique
place in the German literature because it is less
dogmatic and parochial, and more informative
than other comparable texts written in German.

<div style="text-align: right">E. STENGEL</div>

Klinische Psychopathologie. By KURT
SCHNEIDER. (Pp. xii and 170. DM 16.)
Sixth Edition Revised. Stuttgart: Georg
Thieme. 1962.

The title of this book illustrates very clearly the
difference between German and Anglo-American
Psychiatry. The clinical psychopathology which
Schneider deals with has little in common with
psychopathology as understood by the average
English-speaking psychiatrist. Prof. Schneider's
book consists of seven essays on different aspects
of clinical psychiatry, some of which deal with
topics not often discussed in the English literature.
Thus the first essay deals with the concept of
illness and the classification of psychiatric dis-
orders. The author gives a very clear account of his
ideas in simple German which is a pleasure to read.
Fortunately he does not have that common
German misconception that worthwhile ideas can
only be expressed in a complicated tortuous style
which is almost incomprehensible to the German
reader and utterly confusing to the foreigner.
Anyone wishing to study the ideas of German
psychiatry in the original will find this book a very
convenient starting point.

As is to be expected from a German Professor of
Psychiatry, the author pays scant attention to the
views of other schools. For example, in his
interesting article on the differential diagnosis of
schizophrenia and manic depressive disease, the
problem of the marginal or schizoaffective
psychoses is brushed aside and we are told of an
investigation of a series of schizophrenic patients

published in 1939, in which no patient who had any of Schneider's symptoms of the first rank made a complete recovery. There are, of course, quite a number of psychiatrists who would find this difficult to believe. However, despite all criticism this book is an essential part of classical clinical psychiatry, and its appearance in a sixth edition is a welcome event. Those English-speaking psychiatrists whose knowledge of the German language is poor will have to content themselves with Hamilton's excellent translation of an earlier edition, which does not differ substantially from this one.   FRANK FISH

Personality and Social Interaction. By ROBERT H. DALTON. (Pp. 378. 48s.) Boston: Heath and Co. 1961.

'This is a book about individuals and society.' These words preface an ambitious undertaking by the Professor of Child Development and Family Relationships at Cornell University—to present current aspects about personality development. On the cover there is a little reproduction of a Henry Moore sculpture, a mother and child, stating, as it were, the motto theme. Personality is seen as a social product.

The lay-out of the material is novel, consisting of three case-studies each preceded by a review of relevant theoretical work, mainly from the fields of psychoanalysis, field theory, and learning theory, and followed by a discussion and interpretation.

The reader is also confronted with a list of questions about each of the case-studies, in the manner of a student text which indeed this aspires to be. The case material is presented in great detail, and would provide a useful basis for teaching seminars in child psychology and psychiatry. The subjects are (i) 'A Mother–Baby Interaction'; (ii) 'A Family in Transition'; and (iii) 'An Adolescent Crisis'. The first is unusually interesting, being a non-pathological specimen.

In the theoretical sections the author shows great industry, competence and honesty rather than originality. His style is lucid; his manner somewhat donnish. Clearly he has had to prune and select, yet it is surprising to find no reference to the work of David Levy, Katie Woolf or Sibylle Escalona on the mother–child interaction process, nor, in treating of adolescence, to Erikson's

recent papers on 'Identity'. (The last two are mentioned in another context.)

Prof. Dalton's clinical researches are a by-product of psychotherapy, for which he makes no apology, nor need he. Indeed, his discussion of the problems implicit in research into personality is particularly valuable. There is an excellent bibliography.   FRED. H. STONE

Readings on the Exceptional Child. Edited by E. PHILIP TRAPP and PHILIP HIMELSTEIN. Methuen and Co. 1962.

This interesting volume consists of almost fifty papers on the Exceptional Child. The exceptional child of the title is one who by reason of defect or disability, deficiency or disease or exceptional talent differs from the great majority and so may require exceptional treatment. The book is therefore divided into sections on Mental Deficiency (14 papers); the gifted child (4 papers); the aurally or visually handicapped child, the speech handicapped and the brain-damaged and physically handicapped child; while the last section is devoted to 'exceptional emotional processes' (6 papers). The editors who lecture at the University of Arkansas on 'The Exceptional Child' have felt that their students would benefit by becoming acquainted with some of the work now being done on problems connected with the exceptional child and it is with this end in view that this volume has been compiled. Some of the papers have already appeared in print and others are published for the first time. The papers are in the main of two sorts. Some are broad surveys on a particular topic. These give references to other papers which the student can follow up. An example would be the paper on 'Mental Retardation. Concept and Classification', by A. L. Benton, Professor of Psychology and Neurology in the State University of Iowa. In addition to these broad surveys there are papers which are records of particular studies or pieces of research in this field. The aim is to indicate what topics are thought to be of special interest today and what lines of enquiry can be most profitably pursued. The largest number of studies is on Mental Deficiency (14 papers) and this reflects the large number of articles from which the editors could choose. There are relatively few articles on the emotionally disturbed child.

The papers should be readily understood by the readers for whom they are intended and the editors' notes are suggestive and helpful.

These readings are designed to acquaint the student with the contemporary scene; this is exclusively the American scene. Few references are made even in the surveys to work done on children in other countries with different cultural backgrounds. This seems to the reviewer a great lack.

There is an interesting article on 1528 gifted children who have been followed to their mid-forties. It is evident that much work remains to be done in this sphere so that gifted children may be permitted to develop their special capacities to the full.

This book contains a record of much industry but argument, the clash of controversy and the sweep of imaginative thought—so stimulating to the student—seem remote and the enquiring mind will want to range much farther.

J. C. S. SYM

The Sociological Review Monograph, No. 5. Sociology and Medicine, Studies Within the Framework of the British National Health Service. Ed. by PAUL HALMOS. (21s.) University of Keele, Staffs.

This is the fifth monograph issued by the *Sociological Review* and the first to deal with medicine. It contains eleven papers and there are three main varieties of author. Three of the contributions are by non-medical writers—a social scientist, an economist and a professor of industrial relations. Three papers are by doctors engaged in the study of public health. Five papers are by psychiatrists, either singly or trebly or in collaboration with a worker in a different discipline.

The subjects covered include an account of the pressure groups at work at the time the National Health Service was initiated; a plea for extension of private practice; studies of the various attitudes of general practitioners to psychiatry and of their place as family psychiatric advisers. More special enquiries deal with psychosocial issues at an outpatient clinic, a clinical and social survey of three mental hospitals, an enquiry into the medical and social characteristics of elderly people in institutions, and a spirited primary attack on the problem of hospital attitudes and communications which is quite the liveliest of the contributions. There is also a paper on the suicide problem in relation to the National Health Service and,

finally, a useful summary (with an excellent list of references) of recent researches in psychosocial medicine.

Prof. Aubrey Lewis provides a well-written preface which contains the sentence: 'We are, as yet, at a very early stage of enquiry and understanding in regard to the social structure and social effects of our medical services.' This seems to sum it up.

The collection of papers is certainly a mixed bag and it is unlikely that any reader will be interested in all the articles simultaneously. The main value of this monograph is that of a repository of thought and information for present and future workers in the sociological aspects of medicine. It is curious to find that in spite of the re-emphasized importance of communication in sociology only one of the papers is provided with a summary.

J. L. HALLIDAY

Nursing the Mentally Subnormal. By CHARLES H. HALLAS. 2nd Edition. (Pp. 216. 30s.) Bristol: John Wright and Sons. 1962.

From 1923 it was possible for mental deficiency nurses to sit a separate examination and obtain the certificate of the Royal Medico-Psychological Association. By 1927 an independent syllabus had been prepared and in 1931 the R.M.P.A. published its specific *Manual for Mental Deficiency Nurses*—the *Green Handbook*. Unfortunately, no further editions were produced so that when the first edition of Hallas's book appeared in 1958 it was generally welcomed as the logical successor and the first definitive nurses' textbook.

In the Second Edition, chapters on legal aspects and clinical classification which were two of the weaker brethren have been completely revised. An appendix by Richard Short on the recent English and Scottish Mental Health Acts has been added and is quite excellent; its lucid brevity being far ahead of anything in current psychiatric textbooks and for this alone the book would be worth buying. The new chapter on drugs and their indications is useful. Various routine nursing procedures and techniques are dealt with in detail, and there is a helpful section on physical methods of treatment.

The question of rehabilitation receives very proper emphasis and there are many sensible remarks on community care. Strangely enough, there are only two pages devoted to the social

worker while emphasis on physical training without mention of physiotherapy produces a certain imbalance. There is a fine old antique bloom on a few parts of the psychology chapters, but they are none the worse for that.

Essentially, the nurse who reads this book will gather a harvest of general and allied information on subnormality and it is an important volume for anyone working in this field. The index is good. In the next edition, which must surely follow, one wonders whether Mr Hallas should not change the title, for the book is valuable not only to nurses, but to social workers, medical students, health visitors, mental welfare officers and postgraduates whose work from time to time brings them in contact with the mental deficiency field.

RONALD C. MACGILLIVRAY

Physiological Correlates of Psychological Disorder. Edited by ROBERT ROESSLER and NORMAN S. GREENFIELD. (Pp. xi–267. $6.50). The University of Wisconsin Press. 1962.

This volume contains the scientific papers presented at an Interdisciplinary Research Conference held at the University of Wisconsin in 1961. It deals with physiological concomitants of a number of varied psychological disturbances and disorders. There is no claim that it is comprehensive—in such a rapidly expanding research field this would probably not be very practicable—but the book does contain a good measure of important current and recent research in adequate detail and generally with sufficient clarity to permit understanding by those of us less familiar with, but aware of, the importance of the physiological aspects of research. A number of papers deal specifically with schizophrenia and some touch on other psychoses and psychoneuroses. Other papers are concerned with such psychosomatic states as obesity, tuberculosis, hives and hypertension as well as somatic diseases in psychiatric patients. The range of the physiological approach is wide and includes studies on intermediate carbohydrate metabolism in schizophrenia, consciousness and the neurophysiological pathways and mechanisms also in schizophrenia, adrenocortical function during anxiety and also in response to everyday environmental emotional variations, stressful and otherwise. In most of these papers the results are assessed carefully and the limitations of the conclusions, for the most part, rightly stressed.

Nearly all the papers emphasize the importance of careful methodology. Some papers deal specifically with experimental methods, others discuss general methodological and theoretical problems. Many such thorny problems arise equally in other fields of psychosomatic research, for instance, problems on the nature and proper use of controls or on the influence of the experimental setting on subject and investigator, to mention but two.

Of particular interest to those concerned with psychosomatic theory is a paper summarizing experimental and clinical evidence favouring the well-known 'specificity of attitudes' hypothesis that in psychosomatic diseases there is a specific relationship between attitude and illness and that there is a different attitude for each psychosomatic illness. Attitude is defined as what the person says he feels is happening to him and what he wants to do about it. Such a theory, which is contrary to current thinking in many quarters, is one with which at least this reviewer has much in common. It would appear to this reviewer, however, that the attitude adopted must be secondary to the underlying personality characteristics of the individual, suggesting that a theory of specificity of personality traits may be more correct. Also of particular interest is the paper on tuberculosis where the findings, from a different approach, are similar in a number of respects to the reviewer's findings in clinical research studies.

In an Introduction it is pointed out that an important requisite of interdisciplinary conferences includes satisfactory methods of communication, implying the use of terminology adequate to one's own discipline yet understood by those in other disciplines with related problems. This most desirable requisite for psychosomatic research, by and large, is satisfactorily achieved by most of the contributors to this book. Would that it were achieved to a like degree in much other current psychosomatic literature.

The sponsors of the Conference are to be congratulated in getting together a well-balanced group of first class contributions to an important topic and for making these contributions generally available in this well-presented, very readable, volume.

D. M. KISSEN

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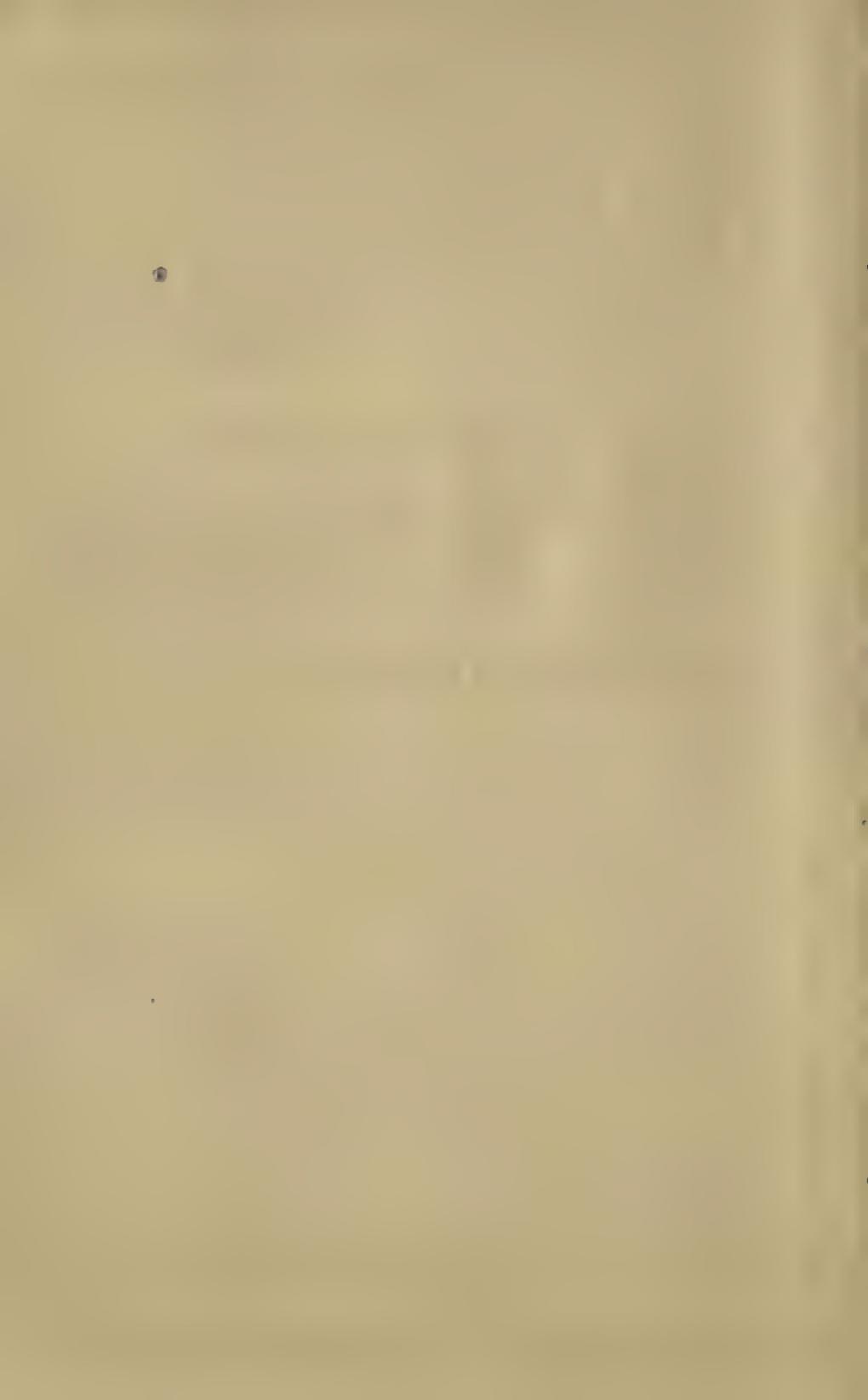
Some regressive phenomena in old age*

By W. H. GILLESPIE†

The subject of our symposium is vast, for the concept of regression is a fundamental one. A simple way of looking at it is to regard regression as the antithesis of those processes of progression, growth, maturation and adaptation which are characteristic of individual development from the moment of conception up to maturity, it is movement in a backward direction instead of a forward one.

When deciding which aspect of regression I should choose for discussion in this symposium, I had to consider that I was sharing it with two acknowledged authorities on the subject, and that I should try to avoid covering the same ground. It seemed best to concentrate on some area which had attracted my own particular interest, and one that was unlikely to be touched on by the other contributors. Perhaps the very nature of our theme, regression, played a part in turning my thoughts back to work I did some 30 years ago, hitherto unpublished. Just now, I contrasted regression with the processes of progression that continue from conception to maturity. It was, in fact, when I wrote that phrase, and found I must write 'maturity' and not 'death' that it occurred to me that the study of regression in old age might be a suitable theme for this symposium.

At an early stage in my psychiatric and psychoanalytic career an appointment at Tooting Bec Hospital gave me the opportunity to carry out a study in a field at that time little cultivated, a field that has now acquired the name of geriatrics. During the 3 years I spent there something like a thousand patients were under my care at one time or another, and of

these some 75%, were over 70 years of age. Psychiatric material of this kind is commonly regarded as uninteresting and unrewarding, but to anyone interested as I was in psychopathology, this proved to be far from true. I found that all that was necessary was to listen, for it was characteristic of many of these patients that they were very ready to talk freely about their pathological preoccupations, such material was ready to hand.

Thirty years ago it was generally taken for granted that psychiatric illness manifesting itself for the first time in old age consisted essentially of senile or arteriosclerotic dementia, characterized mainly by intellectual deterioration. But although Tooting Bec Hospital was designed specifically for this type of patient, nevertheless, a considerable number of the patients were not in fact notably deteriorated in the intellectual sphere but had other psychiatric abnormalities, and these occurred also in a great many of the patients who did show signs of dementia. Examination of a representative sample of 207 male and 204 female patients whose illnesses began after the age of 60 showed that only about half were suffering from simple dementia, some 40%, were demented and in addition showed other marked psychiatric abnormalities, and 13%, appeared quite well preserved intellectually, but suffered from psychiatric disturbances of other kinds. In all then, rather over 50%, had psychotic features other than dementia.

This unexpected finding led me to make a study of the psychotic manifestations of my elderly patients, and to attempt to discover if there were any features of these psychotic illnesses specially characteristic of old age, and if there were any typical psychopathological findings.

* Read at Symposium on Regression, Annual Meeting of British Psychological Society, Bristol 1962.

† Physician, Maudsley Hospital, London.

The commonest psychotic manifestations were found to be:

(1) *Persecutory ideas in the widest sense.* They vary greatly in form and degree, and at the lower end of the scale of intensity they merge into normal grumbles about food, noise at night, or enforced captivity. Then there are ideas of having been kidnapped and plotted against by relatives who have stolen the patient's money. At the other end of the scale are the most intense and painful states of apprehension and terror, often of would-be murderers, who appear in the form of auditory and visual hallucinations and attack the patient by poisoning his food, blowing gases on his bed at night, or accusing him of having committed a crime, or of being diseased. Some patients make attacks on their supposed tormentors, who may be identified with the patient in the next bed or with the nurse. The commonest idea in the more fully developed cases is that the patient is going to be murdered. The patient himself often hears voices accusing him of having committed a murder, frequently of a child; or else he is accused of sexual immorality of all kinds and of being infected with venereal disease. There is nearly always an indignant denial of these charges.

(2) *Depression of varying degree.* Very severe depression is rather uncommon, for the affect of the senile patient is typically labile. He is easily moved to tears when he thinks about himself and his unfortunate condition, particularly when the persecutory ideas just mentioned are prominent, and a moderate degree of dull depression is very common; but one has the impression that the patient is somewhat apathetic and does not feel very keenly the depression which he shows in his expression and his tears. Apart from actual cases of paralysis agitans, which are not infrequent, and are often combined with depression, lesser degrees of the Parkinsonian facies are quite common among these depressed patients. Others appear more typically melancholic. Agitation and restlessness is very common and may reach an extreme degree, more particularly in patients who have also persecutory ideas. They feel they must get away, and are continually getting out of bed and wandering about in an aimless way.

(3) *Hypochondriacal ideas and delusions.* These most frequently concern the bowels, and they are very common. Many otherwise sensible patients will tell one that their bowels have not moved for a week, when there is no foundation whatever for the statement. Less commonly there is a definite delusion that there is a blockage of the bowels, and that nothing can pass through. Other hypochondriacal ideas are fairly frequent, as that the whole body is rotten and stinking, or that the genitals are falling off, usually associated with the idea of venereal infection.

These three groups of symptoms are of course not mutually exclusive, but rather the reverse. The most typical picture consists of a combination of all three. It is particularly the combination of persecutory ideas with depression that seems to be most characteristic of the senile psychoses. The two mechanisms of melancholia and paranoia seem to be interwoven and to have modified each other. Thus, the patient is depressed and agitated, he believes something dreadful is going to happen to him, probably he is to be killed; but he denies that he has done anything to deserve this fate. As a rule he has no feeling of guilt or unworthiness, believes himself to be unjustly accused or attacked, and has a grievance against someone, from whom he desires to escape. On the whole, the mechanism of projection is more favoured, but there is all the time the tendency to introjection, depression, suicidal ideas and hypochondria. The projection seems to function as a defence against this. Other types of reaction are distinctly less common. A small group of patients shows elation, and quite a considerable number have ideas of grandeur, often of a grotesque nature.

In order to obtain a rough idea of the relative frequency of the commonest types of reaction, I made an analysis of the case papers of the psychotic patients in the group chosen

for study (106 male and 111 female patients), with the following result:

	Depressed	Persecuted	Hypo-chondriacal
Males (%)	23	57	24
Females (%)	31	47	18

It will be seen that there is little difference between the male and female figures; there is probably more tendency to persecution in the males, and to depression in the females.

It will not be possible to quote extensive clinical material, but the following extracts from the notes of two typical patients will serve as illustration.

The first case is that of a very miserable, depressed and solitary old woman of 76, who is partially blind from bilateral cataracts. She was apparently well mentally until her admission 2 years earlier. The following is a typical example of her conversation.

They're not going to murder me, now then! (How did you think they would do it?) They are going to cut me up and burn me. They are going to take out my organs. I am not going to be murdered, to have my insides taken out. If I'm to be killed, why don't you take me down to the courtyard and shoot me and be done with it? No, they're not going to burn me either. They put things on my bed and burn it at night.

They say I'm mad. They're all down on me. The action has been stopped. If the bowels are stopped, what is the consequences? That's the cause of a good deal.

I didn't think I was coming to this end—to this sort of thing—to be murdered, and it's not a natural sleep, that's certain. My sleep isn't like it used to be. It is strange. They seem to say I talk and I do all sorts of things.

I had a touch of paralysis, and my mother died of paralysis. That's how I came into the infirmary over there. Bronchial is another thing I had. I got over that splendid—that was four years or more ago.

Why, this is terrible. All this steam and boiling water and freezing in the ward, taking my head out and my chest. They say I say all this. How could I get out of bed and talk like that? It's an absurd idea.

My face is not the same as it used to be—it don't feel the same. It's as if I was bilious. They're taking out wrappers—sheeting—out of the body—when you're born, I suppose. Stockinette, then. That is stockinette on my thumb, fine tiny spots, fine as fine can be.

They say I look like the Devil and all that sort of thing. It's dreadful. I don't want to be killed. Lusty, they call you. I'm as lusty as ever. I don't do that sort of thing.

This case is a good example of that mixed clinical picture which seems to be typical of senile psychoses. In the first place, there is a mixture of psychosis and dementia. The dementia is of a peculiar type, and one is tempted to call it pseudo-dementia. Thus, retention is very good for an address, but when it comes to repeating the gist of a story the patient fails completely. There is a strong tendency to refer the story to herself, and perhaps this explains the difference of reaction to the address on the one hand and to stories on the other. She also denies knowledge of the date, and of her age, though she has a good idea of how long she has been in hospital.

The psychosis itself is also mixed in type. Ideas of persecution and influence preponderate, yet the general impression the patient makes is that of melancholic depression. She is very unhappy, solitary, weeps a good deal, and has the melancholic facies. She believes something terrible will happen to her, that she will be murdered; indeed she believes that these things are already happening to her. Thus, we get many hypochondriacal delusions. The action of her bowels has been stopped. Her sleep is unnatural and is evidently equated with death. Her face feels different, she is being frozen, she is having things taken out of her body.

But instead of accepting all these things as the just punishment for some misdeed, she rebels violently and considers herself grossly abused and illtreated. Everything is attributed to activities of vague persecutors. It is true, she is accused of misdeeds—hallucinatory voices accuse her of being 'lusty' and of doing 'all sorts of things'—but these accusations are indignantly denied. The bad people are all in the outer world. There is a suggestion of insight

into her projective mechanism—'They say I say all this. How could I get out of bed and talk like that—it's an absurd idea'.

Passing to the content of her delusions, it is to be noted that they are chiefly concerned with the idea of being murdered, this idea being elaborated in various ways. The elaborations are bizarre, and bear a very striking resemblance to well-known infantile phantasies. Thus, she believes she will be burned, cut up, have her internal organs torn out, have her bowels stopped up. These correspond very closely to some of the infantile anxieties that have been described by Melanie Klein as being the most terrifying, particularly for the female child; she considered them as representing the punishment for phantasied attacks on the mother's body. This patient says: 'If I'm going to be killed, why don't you take me down to the courtyard and shoot me?' Evidently 'shooting' (which we may take to represent symbolically the father's form of aggression) is preferable to the torture that the mother inflicts. The idea of things being taken out of the body is evidently connected with birth phantasies ('when you're born, I suppose'). The connexion of birth phantasies with ideas of death can be found in a number of senile patients.

The second patient was a man of 82, who up till recently had appeared quite normal, being quiet, of temperate habits and very keen on his work as a tent-maker. He left work 3 or 4 years ago, and it was then that he started to break up and to become queer mentally. He had lost his wife 30 years earlier, but got over this and devoted himself to his two daughters. For some years he had complained about trouble with his water. Later, he started threatening to do away with himself, and one morning he was found on the side of a canal, saying he was going to jump in. He said he was not fit to live, that he had some rotten disease. He was sent to a general hospital, where he became worse, saying that he was going to be cut up, and that they were going to stew him. Opposite his bed was a chimney from which steam issued all day, and he said they were getting up sufficient steam to cook him.

All his life he was extremely clean and would never sit down to table without washing his hands. He worried a lot about venereal disease, and had been thoroughly examined with negative results. He was not satisfied, and now still says he is infected, and that maggots crawl out of him and attack the other patients. He also talks about being the father of cats and dogs, and being responsible for their death.

On examination he is a morose, reticent, depressed and introverted little man, who likes to sit in a corner by himself, with face averted, picking the skin off his fingers and showing other signs of agitation. He is unwilling to converse and is retarded. He is very worried and apprehensive, evidently as a result of hearing hallucinatory voices, which make accusations and threaten him with various punishments, but chiefly with castration or blinding, which seem to be quite synonymous for him. The following is an example of the form taken by his delusions.

They say they're going to give me a bath, and then I'll lose my eyesight. If they cut me, I will. I'm in proper danger here, I am. I wish I could get out of it. (What's the matter?) I've had a bad disease (he shows his genitals). It's here—kind of a pox or something like that it is. I got it sitting on a W.C. I think. It keeps on going, this complaint. I feel like little lumps down there, little spots. (What are you afraid of?) I don't want to lose my genitals. I don't want to lose my eyesight. (How will that happen?) They will take it off. I hope they don't do it tonight. I don't know why they want to take it off at all. It will be semi-blind, won't it? I don't want it. I shan't be able to see to do anything, shall I? They won't take my legs away, will they? They'll only take one thing away. I don't want them to take it off.

As in a large number of male senile patients, mental breakdown occurred only after he gave up his work on account of age. There are probably several reasons for this, as for example that general mental deterioration is the cause of retirement. Then again there is

increased opportunity for introspection and speculation; but I would suggest that an important factor is the impression made on a man by his retirement that he is done, good for nothing any more, and that he might as well be dead.

The most prominent feature of this case is anxiety, and it takes the form of undisguised castration anxiety. This is typical of a large group of male patients, and next to worry about the bowel function it is the commonest way in which they express their anxiety. As in this case, it is usually combined with the idea of venereal infection, either accepted as a fact or projected in the form of hallucinatory accusations. Delusions and fears with regard to the genitals occur also among the female patients, but they are not nearly so common, or at least they are much less frequently expressed.

But other fears are also present in this case. There are more general ideas of being cut up, or stewed, there is the fear of the water in the bath, and there is the fear of losing his eyesight. At first one is perhaps inclined to regard this last merely as a symbolic expression of his castration anxiety. It seems possible, however, that the converse might equally well be true—that is, the castration anxiety might be really a more tolerable substitute for other more primitive fears. I am inclined to think that the castration anxiety of seniles is to be regarded as in part defensive, and that the underlying anxieties are more primitive ones— the fear, for example, of having the whole body destroyed, cut up, burnt or stewed. One might thus conceive of the phallus being offered up as a sacrifice in order to ensure the survival of the rest of the body. In this way, the typical anxieties of the female would be covered up and obscured in the male by castration anxiety.

Let us pass now to some psychopathological considerations.

Most observers agree that the first change noted in senescence is an intensification of already existing character traits; this is well illustrated in our second case, and implies a quantitative rather than a qualitative change.

Such character traits are determined to an important extent by reaction formations, that is, by permanent alterations in ego structure designed to serve as defences against instinctual impulses which would be dangerous or useless to the ego. Hence, if we find an intensification of such defensive character traits, we may surmise that the anticipated danger against which these defences are directed is the danger that the unconscious phantasies may break through into consciousness, and that the instinctual impulses may attempt to find gratification in reality. In this first stage, then, the defensive forces are successful, and the result is merely an exaggeration of character peculiarities.

The next change to be noted in senile patients is their increasing lack of interest in external objects, whether persons or things. At the same time, their thoughts tend to centre more and more on themselves, and everything in connexion with their own persons becomes invested with undue importance. In other words, libidinal interest regresses to a narcissistic level.

This increase of narcissism involves relative independence of the external world and facilitates a more or less complete withdrawal from reality. Thus the soil is prepared for psychosis formation. It becomes possible to neglect the reality principle and arrange things in accordance with the pleasure principle. Unpleasant facts can be denied, and the patient retires into the world of phantasy. The mechanism of repression is of prime importance here. Such denial of reality and repression is most obvious in the manic reactions, but it can be seen to operate also in the depressed and persecuted types; what they fear is not the real danger but a phantasy substitute.

Perhaps the most striking feature of the senile psychoses is the very clear way in which they show libidinal and ego regression. There is a great increase of interest in the excretory functions and in food, reflecting anal, urethral and oral regression. But it is in the phantasies and delusions of these patients that we get the clearest evidence of regression. It would thus

appear that at this stage of the illness the exaggeration of character traits has failed as a means of defence, and the phantasies against which it was directed have broken through into consciousness.

Along with this libidinal regression we find a predominance of the mental mechanisms characteristic of the pregenital phases of development, notably the mechanisms of projection and introjection. Projection is used of course in accordance with the pleasure-principle; thus, everything distasteful is projected. If a senile patient falls and hurts himself, the usual story is that someone hit him. But the most striking thing is that the idea of death is projected. Natural death comes from something inside, whether it be disease or 'death-instinct'; but the typical senile psychotic patient is apparently oblivious of this real internal peril, and is convinced that he is going to be murdered by some outside agent.

Introjection is most obvious in the hypochondriacal cases. A very hypochondriacal patient told me that he had a little man inside his head who caused him a lot of trouble. It is not always easy to observe this mechanism in the depressed cases, possibly owing to the nature of the introjected object, which will be discussed presently. The characteristic mixed paranoid and depressive picture seems to be brought about by the combination of these two mechanisms.

There does not seem to be anything about the phantasies, fears and delusions themselves which can be regarded as specific for senile psychosis, unless it is that they are so largely concerned with ideas of death in one form or another. Very similar delusions and hallucinations were described by Bromberg and Schilder as characteristic of alcoholic hallucinosis.

We have now to consider why the abnormal mechanisms we have observed have been called into play. It has already been noted that the narcissistic regression natural to old age acts as a facilitating factor. Perhaps it may do more than this.

In general, regression tends to follow libidinal deprivation, that is, the loss of a loved object. In such a situation libidinal and aggressive tensions rise and produce anxiety. If the situation becomes intolerable for the ego, it takes refuge in the defence measures we have mentioned. One of these is regression, and the resulting clinical picture will depend upon the level to which the libido and ego have regressed.

But if, as in senile persons, the libido is largely narcissistic, it is clear that the object is the self. The deprivation or disappointment to be looked for in seniles would therefore be a narcissistic one; the lost object must be the self. A senile dement has ample cause for such disappointment with himself—he has only to observe his own physical and mental deterioration. Freud has left open the question whether pure ego damage can cause a melancholic depression. Hollós and Ferenczi made this hypothesis the basis of their theory of the psychic disorder of general paresis.

But what of the cases where there is no dementia and hence no ego deterioration? The traumatic agent here appears to be not so much actual deprivation as the threat of it. The threat is ultimately the threat of death, and the fear of death is the anxiety that has to be dealt with. The fear of death clearly requires further analysis, for in so far as death is equated with a state of peace and complete absence of tension it should be felt as desirable. But it is evident that death is liable to be envisaged in an entirely different way, namely as a withdrawal, not of all pain, but of all pleasure, as the state of complete deprivation to which Ernest Jones gave the name 'aphanisis'. Castration anxiety may be regarded as a special form of this fundamental dread, which is common to both sexes. The idea of complete annihilation is foreign to the human mind, at any rate to the unconscious mind, so that this dread is not modified by the reflexion that in the case of his death the person will not be there to feel the deprivation.

This fear that everything worth having is to be taken away may be called forth in its maximal intensity by the idea of approaching death. It may be aroused by bodily illness, but

also in a number of other ways, especially by circumstances which impress upon the patient the fact that his former capacities are leaving him. Thus, he finds himself unable to obtain employment owing to his age, his sight is failing, his potency impaired; in short, he sees himself approaching the stage of 'sans everything'.

Apart from general theoretical considerations, the clinical facts which led me to regard the fear of death as the most typical (I do not suggest universal) traumatic factor in the production of senile psychoses are two. First, the abundant evidence of repression of the idea of natural death in senile patients; and secondly, the 'return of the repressed' in the form of delusions of being killed.

I would also suggest that the traumatic, precipitating factor may be relatively more important in senile psychoses than in other types of psychosis. Heredity seems to play comparatively little part, and it seems improbable that a person with a strong predisposition to psychosis should reach the age of sixty without breakdown. The ordinary stresses and strains of life have not upset the equilibrium of these patients. It therefore seems reasonable to seek a precipitating cause in some more or less specific senile factor.

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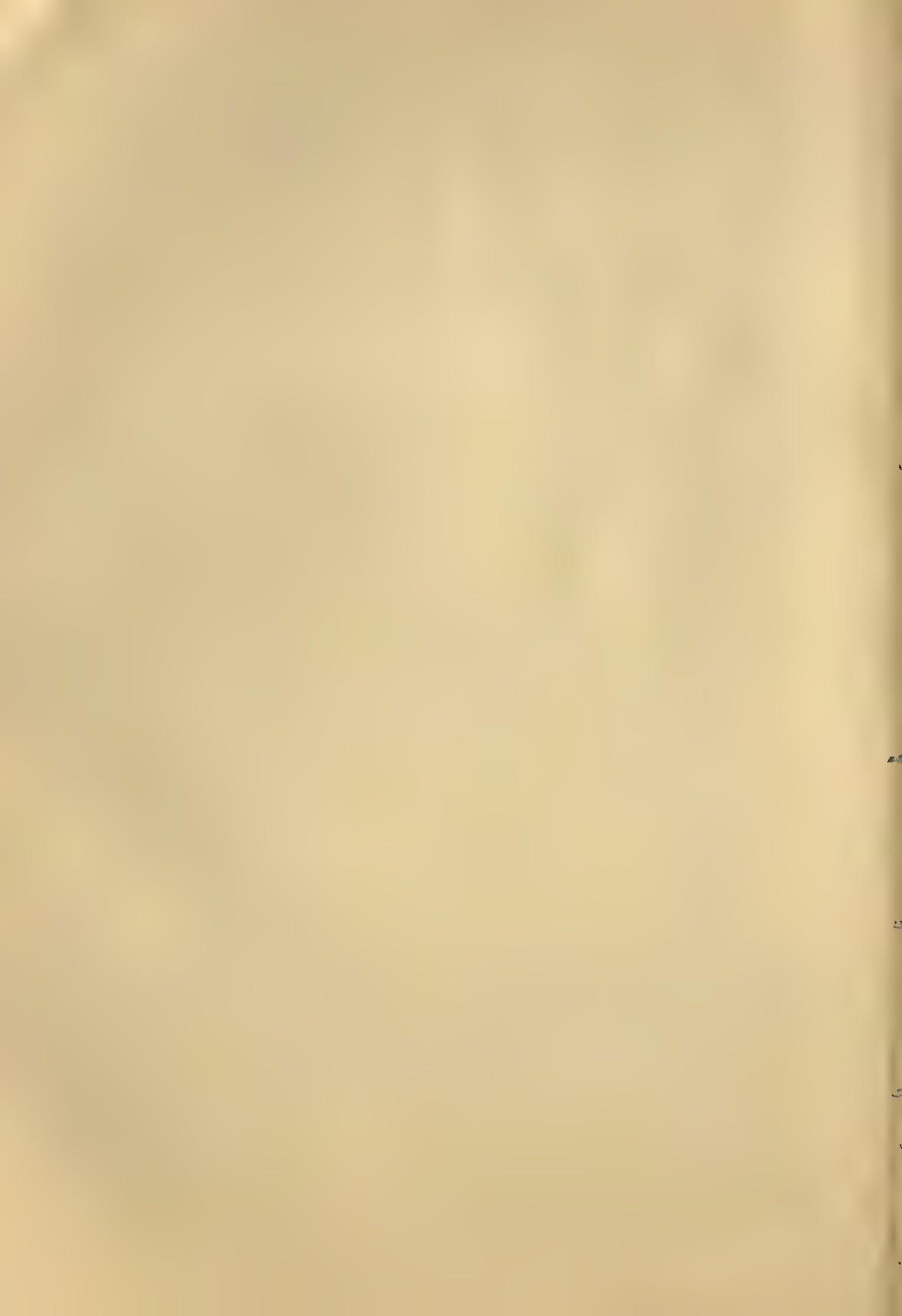
Psychogenesis in asthma

An appraisal with a view to family research .

By J. E. WEBLIN*

So long as asthma is ranked amongst diseases that are peculiarly nervous, so long can we never hope to come to any *correct conclusions*; the idea being so vague and the laws which govern the nervous system for the most part so incomprehensible[1].

How the venerable physician of yesteryear explained the paradox of discerning comprehensibility using a mechanism—his own nervous system—which works incomprehensibly is not clear. But the illogic of both his remark, and my retaliation, underlines the problem of knowledge—whether it be about asthma or anything else, i.e. *the knowledge is not the thing itself.* The mirage..., lest we forget....

But it is to be hoped that physicians, pathologists, endocrinologists and kindred brethren, will be not discouraged too readily from making yet one more attempt to negotiate the seemingly uncharted perils of psychiatric seas.

* * *

This paper attempts an assessment of our present understanding of the question of psychological factors in the genesis of bronchial asthma. Is is based on a representative review of the literature, and whilst it essays some comment on the status of allergy theory and attempts to harmonize this with the 'psychological' side, it is oriented more toward a research scheme for studying the asthmatic patient and his family in an interactional setting.

It is difficult to adhere strictly to Koch's

postulates in psychiatric nosology. In consequence, with relevant considerations for pathogenesis being hopefully implicit, where they are not explicit, the deliberations presented here will be ordered around topics as follows:

Part 1
  (A) Respiratory function as an indicator of emotion
  (B) Does asthmatic wheezing have a *meaning*?
  (C) The personality of the asthmatic patient
  (D) The early environment of the asthmatic patient

Part 2. Asthma as the 'chosen' symptom
  (A) Allergy in asthma—some problems for theory
  (B) Requirements for a learning theory of asthma

Part 3. Discussion

Part 4. Conjoint family therapy (suggested avenue for research)
    Summary

PART 1

(A) *Respiratory function as an indicator of emotion*

The word asthma comes from the Greek word meaning panting. In 'common' English parlance, we 'hold our breath' in surprise, and 'sigh with relief' as the imprisoned breath escapes. Shock can even 'take the breath away'; we can 'choke' with emotion. Human situations can evoke a 'stifling' atmosphere; parents can 'smother' their children with affection. On the other hand, a person can be like a 'breath of fresh air'; we can get trouble 'off our chest', and can 'explode' with mirth.

It seems that the human unconscious is

deeply aware of the ebb and flow of the breath as a signal of the soul's true weal!

Sexual excitement, crying and laughter involve obvious alteration in respiratory activity.

Breath holding spells in children are regarded as a purely psychogenic upset, see Kanner[2], who also speaks of pseudo-asthmatic respiration in response to emotional stress, a phenomenon which closely resembles clinical asthma.

It is perhaps not too far-fetched to see in all this that anxiety-laden emotion can have an equivalence in retained or imprisoned breath, and that from the mildest to severest extremes emotional factors alone* appear able to generate respiratory activity with some, or almost all, of the characters of asthmatic wheezing.

(B) *Does asthmatic wheezing have a meaning?*

Launched now into consideration of 'true' asthmatic breathing, can it be said, of itself, to have a *meaning*?

There has been a widely expressed view that it is equivalent to *repressed crying*, and the work of Dunbar[3], Fenichel[4], Jessner *et al.*[5], Long *et al.*[6], French & Alexander[7], Mohr *et al.*[8], Alcock[9] and Barendreght[10] should be consulted for illustration of the various ways this idea has been developed. It suffices here to say that these authors see the asthmatic person imbued by fear of separation from mother, or 'mother-figure', with a fear of the loss of love running centrally through his life. The repressed cry is seen compounded of repressed grief, and anger, over what these writers and others, particularly Miller & Baruch[11], see as parental rejection. Whilst the exact meaning of a repressed cry is perhaps elusive, it is difficult not to be impressed by certain evidence, viz. that in psychoanalysis some asthmatics have shown a dramatic response—stopping wheezing in the process— to early 'confession' (of anger and guilt feelings, etc.) resulting in profuse crying (see

G. Wilson's contribution in French & Alexander[7]); also French & Alexander speak of dreams of fear and hostility resulting in nocturnal attacks of asthma. Isolated, but significant, case-history reports, as in one quoted by Knapp *et al.*[12], speak of children being punished for crying. Very recently Turnbull[13] has attempted to base, in part, a learning theory of asthma on a concept similar to the repression of crying.

Some of these workers feel that a strong *sexual conflict* is involved in asthma, and see a marked erotic significance in attacks. French & Alexander, the importance of whose monographs as a fund of information and ideas can be scarcely overstressed, make reference to sexual dreams which end in nocturnal attacks, and they note the frequency and severity of attacks associated with love affairs. Inasmuch as the latter imply a decisive, intrapsychic at least if not always overt, separation from mother, then sexual and grief–anger conflict can be seen as complementary themes.

Homosexual, as well as hetero-sexual, doubts and fears are said to be common too.

Dunbar[3] also finds in asthmatic attacks, especially in children, an equivalence to a *compulsion neurosis*.

Inasmuch as several workers see a marked *depressive underlay* in the asthmatic personality, this point is not without interest in speculating about the repressed cry, for one recalls how difficult many depressives find it to cry.

Finally, in so far as asthma has been felt to correlate negatively with psychotic illness, and notice taken that psychotic phases and asthma alternate, but scarcely ever co-exist, it has been speculated that asthmatic attacks are *equivalent to psychotic processes*. The work of McAllister & Hecker[14], Leavitt[15], Sabbath & Luce[16], Funkenstein[17], Knapp *et al.*[12], and a recent review by Mandell & Younger[18], should be consulted. The concept is controversial, and is of uncertain value, because the *meaning* of psychosis still poses a problem.

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* Ignoring for the moment the question of *individual susceptibi ity.*

(C) *The personality of the asthmatic patient*

If psychological stress is important in the development of asthma, there should be signs in the patient of personality disturbance, of whatever degree, resulting from this. The search for, and understanding of, such evidence has occupied many workers.

Knapp & Nemetz[19] found 83 % of forty adult asthmatics subject to episodic depression of varying kinds between attacks—almost all are depressed during them—but seldom reaching psychotic intensity.

Dunbar[3] has reviewed the literature on asthma from the first 35 years of the century, and some later. She finds that writers like Fromm–Reichmann see a similarity in asthma to manic-depressive psychosis. It is interesting to note that whilst the latter is uncommon now in classical form, asthma continues unabated.

Brown & Goiten[20] also discover a cyclothymic disposition in asthma, coupled with paranoid features, but find a cross-section of other personality disturbances also.

Neuhaus[21], who considers that there is widespread agreement about the personality structure of asthmatic *adults*, sees overanxiety, lack of self-confidence and dependancy as central features.

The interesting analytic case description of Lofgren[22], and of the various authors in the French & Alexander monograph Part II, appear to bear out most of the above impressions, though in anecdotal, unsystematized form.

Barendreght[10] in attempting to demonstrate a comparative specificity between the asthmatic and the peptic-ulcer personality, concludes that the former shows, *inter alia*, much more evidence of hostility and impulsive behaviour than the latter.

But it is on this question of *specificity* of the disturbances noted that important disagreement exists. Leigh[23], for example, can find no evidence for it, and Knapp *et al.* conclude that despite the incidence of depressive episodes, 'no single personality profile' exists for

asthma. Further, studies of personality in asthmatic *children* have led to just as much uncertainty.

Thus, while Alcock[9] in a controlled study with normals and chronically sick children finds tension, restraint, and paranoid ideation common, Rappaport[24], considers that asthmatic children's emotional problems are no different from those of any other chronically sick child, and regards them as purely secondary phenomena.

Harris[25], in a study based retrospectively on school-teachers' reports, finds no evidence to indicate that asthmatic children's behaviour is easily differentiable from that of non-asthmatic children.

Neuhaus[21]—in a swing back of the pendulum—obtains very different, and to him, even astonishing, results in a study using personality inventory and projective tests on asthmatic children with their sibs, 'cardiac' children and their sibs, and normals, as controls. He discovers that all the first four groups show a significant and equally greater evidence of maladjustment and neurosis than the normals, but is uncertain of the meaning of the findings, and he even questions the sensitivity of the tests used. The results of a recent study by Block[26], using similar material, are awaited with interest.

Mohr *et al.*[8] have introduced a fresh concept in the view that asthmatic children tend to show marked *pseudo-maturity*, with striving towards an artificial independence.

Irrespective of the issues of specificity, and whether the problems precede or are consequent upon the asthma, Kanner[2] concludes that '...by no means all asthmatic children are "insecure" or "lacking in self-confidence"'. He quotes Gunnarson as finding psychological components in slightly more than half a series of fifty-eight children.

(D) *The early environment of the asthmatic patient*

The sources of psychological stress are generally looked for primarily in childhood experiences; and questions of parent–child

relationships, inter-parental harmony, personalities of sibs, etc., have received attention by a number of authors.

Some earlier analytic writings, notably of Deutsch[27] and also those of Dunbar, French & Alexander, and Fenichel—to which reference has been made—express conviction over the prevalence of conflictful early life experiences. Focus is put particularly upon the child's fear of separation from the mother, as mentioned previously. Detailed case reports, where given, almost invariably reveal homes marked by overt disturbances such as divorce, alcoholism, and early parental death, or permeated on the other hand by coldness or parental eccentricity. In others, homes have been overshadowed by chronic, severe parental illness. In a detailed recent study of ten cases, Wittkower & White[28] discovered that three of them had lost mothers, and four had lost fathers, during childhood. Some of these situations involved obvious physical separation from mother.

Where less gross forms of maternal deprivation are concerned various workers have described the nature of this in different ways. Miller & Baruch call it all *rejection* and find a rejecting attitude present in nearly 100% of mothers studied. Jessner *et al.*[5] feel that the mothers show a clinging dependence on the child, coupled, however, with a tendency to push them to premature independence, and see these as *alternating, reciprocal facets of rejection.* Rogerson *et al.* [29] in early work from a psychological viewpoint, saw the maternal attitude as one of *overprotectiveness compensatory to inner feelings of rejection of the child.* Abrahamson[30] has viewed the situation rather as one where the parents and child are locked in mutual *engulfment,* an evocative term doing some justice to the complexity of these emotionally charged predicaments.

Some psychometric studies, notably those of Fitzelle[31] with parents and Neuhaus with siblings, respectively, have been carried out with the immediate relatives of asthmatic children. Reference to the latter has already

been made, and Fitzelle's study, similar in its way, used parents of chronically sick children for comparison. The results are much the same, namely, that parents of asthmatic children rate highly for maladjustment and neurosis, and the 'chronically sick' parents likewise.

These findings, if confirmable, suggest strongly that the asthmatic child is reared in a 'sick' environment, but this does not deny the possibility that, given a precariously poised but functioning family, the arrival of an asthmatic child may eventually 'rock the boat' seriously and permanently. I know of no long-term study where the personalities of family members have been investigated 'before and after' the impact of an asthmatic child.

Two quite recent groups of work have contributed to a more dynamic understanding of the early milieu of the asthmatic child, namely that of Mohr *et al.*[8] and of Wenar *et al.*[32]. Mohr's group, in psychoanalytic sessions with child and mother, individually, and featuring some interviews with father, joins with some earlier viewpoints in seeing the mother as a dominating, controlling figure, with the father meek and dependent. This group contributes a challenging opinion about the timing of asthmatic attacks; namely, that they occur when inter-parental hostility comes into the open. The attack, they suggest, in uniting the parents in care of the child, restores a precarious peace and with it his tenuous supply of affection. The child, pushed to *pseudomaturity,* thus has an important part to play in maintaining a guilt- and resent-laden symbiotic system. The value of this dynamic picture of the 'asthmatic family' suffers a little in that it is based apparently on data unevenly drawn from the three members of the system, and one wonders how far a fuller contribution from the fathers would have modified the conclusions.

The studies of Wenar *et al.*[32] devoted to mother–child relationships included asthmatic children in a larger 'psychosomatic' group studied. Using various interesting tests, their picture of the mothers is similar to that of Mohr and others; but of special interest to

our present purposes is that Wenar's methodology included direct viewing of mother–child interaction from behind one-way viewing screens.

One further—as yet unpublished—study, that of Block mentioned briefly earlier, also has employed direct observation of parent-child, and mother–father, interaction. It seems likely, as the planning of our own project shows, that interactional observations will play a growing part in the investigation of psychopathology.

Finally, though tangential to our present direction, mention must be made of the very interesting work on the nature and intensity of the mother–child bond as it is reflected intra-psychically in the patient. Using various techniques such as dream interpretation, children's play fantasies, and TAT responses, French & Alexander, Jessner *et al.*, Long *et al.*, and others, have become impressed with the prevalence of 'claustral' or 'intrauterine' themes, in which a longing for, or fear of—perhaps both—enclosed spaces and water is prominent. There is room for speculation about what these notions mean, and how they have achieved reinforcement to survive extant into adult life. However, the intra-uterine theme receives a little gloss in the observations of Jessner *et al.* and Mohr (in French & Alexander, Part II) that birth histories of asthmatic children often show an unusual incidence of delayed or difficult labours. Does mother reveal her clinging even at this early stage...?

* * *

PART 2. ASTHMA AS THE 'CHOSEN' SYMPTOM

At this point it is clearly important to raise the issue of *allergy*, for the question of 'choice' of respiratory symptoms would be widely regarded as meaningless without invoking the concept of allergic sensitivity in the bronchial tree.

It is accepted there that asthma attacks can occur in response to allergic stimuli, and the task as envisaged in a study of psychogenesis is to attempt to reconcile the basic fact of 'allergic response' with processes more easily regarded as 'psychological'.

With respect to asthma some problems pertaining to allergy emerge, but in discussing them no pretence is made to an adequate coverage of the body of allergy theory as a whole.

(A) *Allergy in asthma—some problems for theory*

(i) *Allergic vs. psychogenic asthma.* It is difficult nowadays to find much support for a distinction between these supposed 'pure strains' of asthma. Occasionally an ingenious attempt, such as that of Bray[33], has been made to attribute everything, from irritability to enuresis that can go with asthma, to a pervading allergic disruption of mind and body.

An important study of Dekker *et al.*[34] has, however, recently demonstrated that comparable groups of asthmatics, labelled allergic and non-allergic according to their response to inhalational and skin tests, score equally highly with a typical neurotic group on a well-tried rating scale for neuroticism.

There is a line of evidence however in the study of Feingold *et al.*[35] which on a rather different basis of allergy sampling appears to diverge from this, though the significance of the difference is not easy to evaluate. Using a Personality Inventory (M.M.P.I.) on allergic—not only asthmatic—women, they find that weaker skin-test reactors tend to be more deviant on the test than strong reactors, who in fact claim a closer approximation to normal social interaction. An exception was that scoring tended to be reversed on the K scale, which may suggest that a dominating 'conventionality' may mask a deeper meaning to the responses in the rest of the test than is apparent—though this is highly speculative.

The important question arises—of course—about the primary, or possible secondary nature, of psychological disturbances, both in the patient and his family. Could they be a response to the upheaval and restrictions of a chronic distressing illness in the family? It

cannot always be shown that maladjustment occurred prior to the commencement of asthma, or—where it develops very early in life or is preceded by infantile eczema—that disturbed parental interaction preceded the child's birth. This is often perhaps because retrospective accounts from parents or patients are incomplete, but it cannot be assumed that this is invariably so.

(ii) *Inconstancy of reaction to allergens.* Whilst some patients have attacks with great regularity when exposed to their particular allergen(s), this is not always so, and it is doubtful whether this is adequately explainable on immunological grounds alone.

(iii) *Alleviation of asthma by psychological intervention.* Both Diamond [36] and Mason & Black [37] report on the apparent cure of intractable asthma by hypnosis—including on occasion even the abolition of positive skin tests. There are also numerous reports of success of psychoanalysis and of other simpler psychological therapies, though these results so far lack perhaps adequate collation and evaluation to satisfy critical scientific appraisal.

Certain aspects of the dilemma facing an attempt to rigidly separate allergic and psychogenic factors are well shown by the work of Long *et al.* [6], who like Peshkin & Tuft [38] in their description of 'parentectomy', have treated institutionalized, intractable, asthmatic children. Not only did the asthma attacks invariably cease within 2 days of admission, the children no longer had attacks when exposed to sprays of their own house dust, despite obvious sensitivity prior to hospitalization. Furthermore, the children commonly had attacks when notified of the parents' intention to visit, or during a visit.

(iv) *Whence the allergic sensitivity?* Prominence is given, clinically, to establishing the presence of a familial, inherited allergic disposition to asthma, eczema and hay fever. While the familial trend is often undeniable, it is perhaps doubtful whether—as it were— Johnny's asthma is proven as inherited, just because Aunt Sue had hay fever, and Grandma suffered from eczema as a little tot.

Moreover, it is rare to find a specific mode of transmission cited. Bray [33] has suggested a Mendelian dominant, but Wittkower [28] finds the evidence inadequate, and he goes on to point out that a tendency to other illnesses, especially serious respiratory illness in general, often preponderates over known allergic maladies in these families. He suggests that a 'susceptible respiratory tract' should be the more general focus for genetic thinking. Asthma may of course arise without any allergic family history.

As a possible alternative to the problematic hereditary nature of asthmatic allergy, have any mechanisms for its development on an acquired basis, after birth, been suggested? This overall issue, which could raise deep immunological issues, is beyond my scope, but I wish later in this paper to set forth again a possible mechanism for allergic acquisition, hinted at by earlier writers, which by repetition in a family tree could *mimic* inherited transmission.

Thus, for present purposes one is perhaps justified in regarding the role of allergy at slightly less than face value. But in doing so one is obliged to try and propose an alternative interpretation as a basis for the simultaneous presence of allergic phenomena and emotional disturbances in the same patient.

(B) *Requirements for a learning theory of asthma*

(i) *Emotional disturbance and asthmatic breathing.* It is generally felt that any form of learning, including that of a neurotic symptom, requires two kinds of processes: (*a*) an initial association by chance, or by some 'trial-and-error' process, of the particular behaviour with a state of high drive (fear, anxiety, etc.); and (*b*) the subsequent repeated reinforcement of this association through its success in relieving the state of drive. This is a very scanty outline of the application of conditioning principles to the learning of neurosis, but it is essentially that which is embodied in many current writings, e.g. that of Turnbull, mentioned shortly.

In its simplest form a way is thus hinted at whereby, through unconscious imitation of, or identification with an asthmatic member of one's household, a person might learn, or 'catch'—literally 'grasp at'—a habit of wheezing respiration. Should this then be followed by adequate reinforcement in the form of an increase, or restitution, of maternal attention in an otherwise deprived relationship, established asthma might result.

In seeking a mechanism for situations where there is no asthmatic progenitor, we find that Turnbull[13] has devoted considerable attention, among other things, to crying; noting that it is a universal phenomenon in young children, he also regards it as being essentially asthma-like in character. He suggests that an infant's crying is a particularly severe source of conflict to the mothers of asthmatics-to-be, and that the mother responds in some kind of aberrant non-rewarding way, e.g. by punishment or by ignoring it for a prolonged period. He holds that this situation is one in which sighing, gasping, coughing or wheezing—being common respiratory accompaniments of prolonged or disturbed crying—would readily replace it if sufficiently rewarded by mother's renewed care and attention. The crying would then in fact undergo extinction. If this is a basis upon which human asthma could develop, there is very suggestive confirmatory evidence from animal experiments, which Turnbull also discusses. Thus the idea of the 'repressed cry' is reborn in modern garb.

There is a theoretical problem here though, in that reduction of a simple drive, anxiety, is perhaps an inadequate explanation of this learning; for it is likely that the infant drive is a complex one of anxiety *and resentment*, or frustration, and that the maternal response is similarly compounded. The problem this poses for learning is hinted at by Turnbull, and it seems likely that the concept of instrumental conditioning needs expansion in explaining neurotic behaviour. But at present the model must serve our purposes.

In seeking how emotional conflict and respiratory symptoms become coupled, it is clear that respiratory illness in general could provide a focal meeting-point for anxiety and distorted breathing. We could speculate that, between the 'imitating asthma' and 'replacement of crying' models just outlined, a whole range of complex learning mechanisms is 'available' to a child in a family situation where respiratory illness and serious emotional conflict are present together. The 'requirements' could be met by respiratory illness in either a significant other family member, or in the pre-asthmatic himself, or both. Is there any suggestive evidence in support?

Departure into detailed references would serve no purpose, but Deutsch[27, 39] and Jessner *et al.*[5] have written along these lines, and more recently Wittkower & White[28]. The detailed case histories in the French & Alexander monograph abound in close relatives suffering from tuberculosis, pneumonia, chronic bronchitis and congestive heart failure. Bray[33], quoting from his own and others' work, is impressed—though from a different viewpoint—with the high incidence of serious antecedent respiratory illness in asthmatic children. Knapp & Nemetz[19] note that half of their forty cases had ruminative fears about their nasal cavities out of all proportion to respiratory lesions they had themselves suffered, which again suggests a learning process in a family milieu.

To conclude this trend of thinking it is necessary only to add that other kinds of 'assault' (actual or phantasied) upon the respiratory tree could, according to their severity, enhance the learning process. Whilst not necessarily regarding them in this light, the above authors refer to instances which can be mentioned here without comment: e.g. a mother used to throw water over her child to stop breath-holding attacks; another child was smacked for the same behaviour; one case had her throat forcibly sprayed, and her limbs held, for repeated attacks of tonsillitis as a child; a boy received threats of drowning for not stopping his enuresis; inhalational anaesthesia, often for tonsillectomy, is common in early histories as also are fearful early experiences

with water—to name only some of a wide range of situations quoted.

(ii) *Allergy and learning processes.* The possibly constitutional basis of allergic wheezing will be referred to again shortly, but the conditioning experiments of Dekker et al.[40] and of Ottenburg et al.[41] could be construed as paving the way for an alternative interpretation. A leap into conjecture could regard potentially allergenic substances, such as house-dust and pollens, as elements in the 'inhalable environment' during the previously discussed asthma-learning situations. These substances (indeed, theoretically, any stimuli, like the colour of the wallpaper or a creaking floorboard) might, because of their association, become asthmogenic alone if selective reinforcement operated. Under what circumstances, through what mechanisms, might responses to inhalable substances—being those more usually involved—become reinforced?

Two hints that possible reinforcing circumstances might exist at the physiological level are implicit in the suggestions (*a*) of Bray[33] that previous infection traumatizes the mucosa of the bronchial tree and predisposes it to the allergic-type response, and (*b*) of Wittkower & White[28] who notes, in reference to Allergic Rhinitis, that in states of heightened or conflict-laden emotion there is oedema and congestion of the nasal mucosa which is sensitized thereby to allergens. As sinusitis, hay fever and polypi tend to be common in asthma, it could be conjectured that a similar mucosal mechanism might operate lower in the bronchial tree along with bronchospasm; the latter in itself might be 'fear-induced' via an automic mediation, or be a phenomenon of 'voluntary' hyperventilation in stress, as suggested by the work of Dekker et al.[42].

This highly speculative proposal has two possible merits. First, it suggests the possibility of seeking experimental evidence in the *constitution* vs. *environment* controversy using asthma-prone animals. In these, asthma sensitivity could be traced in breeding experiments over several generations where the total environment (e.g. shape and colour of cage or box; 'allergenic inhalants'; exposure to infection and to psychological stress, etc.) could be under constant control and be sensitively varied. Secondly, it might go some way to explaining inconstant and paradoxical responses to allergens in humans; i.e. if we could regard the psychological environment not only as a long-term determinant in the overall asthma-learning process, but as an important factor influencing allergic reactivity in the bronchial mucosa 'here and now'. An occasional case report lends itself better to a conditioning theory of allergy than to any other, as, for example, the case mentioned by French & Alexander[7] in which a patient, allergic to the vapour of creosote, recalled that creosote was the fuel of a lamp used to treat his croup as a small child.

However, it is clear from the foregoing that a 'constitutional' theory for asthmatic allergy is at least as feasible as any suggested alternative. It is clear also, that as an unconditioned response wheezing might itself initiate learning situations. Being a frightening experience it could lead to fear becoming associated with disturbed breathing of any origin—be it emotional hyper-ventilation, crying, coughing, etc., or the hyperpnoea of infection or of violent exercise. The mutual reinforcement of events associated with these various factors could lead, via stimulus generalization and mediating agents, to complex patterns of causation whose origins might well become considerably obscured. Thus even though the 'psychogenic vs. allergic' dichotomy is difficult to sustain in its extremes, we might perhaps have a reasonable theoretical basis for 'mixed' cases where there was a relative predominance of one component or the other. Lofgren's astonishing case, in which an adult asthmatic woman had, as a child, been nearly strangled to death and had watched a relative's gasping death agony, to name only two of her bizarre experiences, suggest that many cases are over-determined, irrespective of the *original* mechanism.

* * *

PART 3. DISCUSSION

The times are out of joint, o cursed spite
That ever I was born to set them right.

Hamlet can serve as no model for an attempt to evaluate the foregoing. So vast, and at times so speculative, is the scope of asthma research that I must limit my comments to two controversial areas—namely the study of *personality*, *maladjustment*, etc., in the asthmatic patient *and* the description of his *early environment*—these areas being particularly relevant to the approach of family research about to be advocated here.

Furthermore, I am concerned more with *how* such differing conclusions in these areas can, and have, come about, and with some almost 'built-in' problems of the research rather than with a detailed evaluation of the merits of individual conclusions. My 'sub-topics' here will be:

(*a*) *The influence of the observer (investigator, researcher, etc.).*

(*b*) *The search for meaningful data.*

(*c*) *The nature of 'sickness', 'normality' and 'health'.*

(*a*) *The influence of the observer.* Despite the considerable variety of conclusions reached about both the personality of the asthmatic, and about his early environment, it is important to realize that these apparent 'differences in opinion' are better regarded as different 'viewpoints', or more correctly aspects of behaviour looked at from different 'viewpoints'. If this seems rather self-evident, this cannot be said of the implications attached to the fact that the many 'different opinions' are often based on research or testing methods dissimilar in scope, 'depth' and certainty of interpretation; which brings us to the first point, i.e. the selection of a method of investigation involves an inescapable value-judgement on the *nature of the phenomena* 'asthma' and the 'person-with-asthma'. This, like any other value-judgement, has its origins in the whole life and experience—by no means limited to the fragment we call 'professional'—*of the observer* up to that moment; the decision is not auto-matically relevant to the subject(s) or patient(s) about to enter the scene. These people do not experience, as it were, their lives or personalities divisible into the categories of 'Rorschach responses' or items on a 'personality inventory', helpful though this divisibility may be to that aspect of the scientist's personality which we may call 'professional'.

This aspect of research—ignored as often by their critics as by investigators themselves—leads logically to the allied problem of the *interpretation of data*, be it about similar or conflicting findings. Sapir[43] has expressed it thus: '. . . he [referring to "the genuine psychiatrist"] best realizes that the same types of behaviour, judged externally, may have entirely distinct, even contradictory, meanings for different individuals.' While certainly applicable to the question of the asthmatic personality, this problem of the *level of description or interpretation* of behaviour is perhaps *best* exemplified by three studies of the asthmatic's early environment, namely, those which conclude that the child is subjected to:

(i) *Maternal rejection* (Miller & Baruch).

(ii) Alternating parental attitudes of *clinging dependence and pushing to premature independence* (Rogerson *et al.*).

(iii) *Engulfment* (Abrahamson).

Given adequate comparability of the groups studied, it is difficult to conclude other than that these descriptions represent *varying penetrations of view* between the authors, again a factor largely independent of the subjects under investigation.

Finally, in considering the influence of the observer, we have to realize the flaws in assuming that one and the same investigation or test procedure can be administered uniformly from occasion to occasion. Even with apparently well-standardized psychometric methods, the effects of unplanned 'verbal conditioning' and 'non-verbal' stimuli from the observer, either before or during the investigation, may well be very important; understanding of these phenomena belongs to

a branch of communication study in its early, but stimulating, stages of development.

(b) *The search for meaningful data.* Partly consequent upon awareness of the above issues, we can see how inevitable it is that a considerable variety of methods have been utilized to increase 'scientific' understanding of asthma. Looked at differently, this array of techniques can be seen to polarize into two general kinds of approach, and so pose a real dilemma in planning research:

(i) Methods of limited scope designed to illustrate *certain aspects of asthma*—like those alluded to above—and which are often capable of definition in the form of concise psychometric tests. These generally yield data 'easy to handle' but difficult to integrate into an *over-all picture* of the illness.

(ii) Laborious 'depth' methods such as prolonged psychotherapy or psychoanalysis, whence—as seen in the French & Alexander monograph—the data is rich and abundant but *difficult to abstract* for scientific purposes. Here again the observer-influence is marked, and even though it be claimed as 'inert' or of a 'blank-screen' nature, its effect is still very difficult to evaluate.

(c) *The nature of 'sickness' and 'health'.* There are two groups of work, at least, in the research here reviewed which raise this matter prominently. To refer the reader back they are:

(i) The studies of Dekker *et al.*[34] and of Feingold *et al.*[35] concerning the question of relative psychological health in asthmatics with (a) weak and (b) strong, allergic reactivity, and (c) in those without allergy.

(ii) The studies of Alcock[9], Fitzelle[31], and Neuhaus[21] in which the mental health of chronically sick children, and their parents and sibs, is contrasted with that of asthmatic children and their families' members.

Close examination of these studies does not remove doubt that serious conceptual problems may be involved. In fact what emerges as a possible implication is that inadequate awareness of the nature of 'sickness' in contrasted groups is involved; also that 'health', if viewed as a statistical 'norm'—as in many psycho-logical tests—among 'average populations', may be very misleading. These issues are of central importance to a holistic or 'psycho-somatic' approach to medicine, and the two main questions which this has to pose are:

(a) Does psychological conflict play a far more important part in the production of *all* disease than hitherto realized?

(b) Can this conflict be so 'concealed' in social functioning which, though widely regarded as 'normal'—even laudable—is in fact far from *healthy*, or may it be 'manifested' in a wide range of somatic disease, or both?

* * *

It would be absurd to claim that the methodology becoming known as *conjoint family therapy*, being the particular approach in family research here favoured, could remove the three major problem areas discussed above or supplant the techniques involved. Nothing is likely to do so. It is seriously contended, though, that it reduces the 'observer influence' problem markedly, bids fair to soften the 'methodology selection' dilemma, and may help illuminate current concepts of sickness, health and normality. The paper will now conclude with a further few words on these points and with suggestions how the conjoint family method might be expected to contribute to understanding in the overall picture of asthma.

PART 4. CONJOINT FAMILY THERAPY (A SUGGESTED AVENUE OF RESEARCH)

It is unnecessary here to trace the origins and development of the conjoint family approach, be it used as a diagnostic or as a therapeutic technique. The interested reader is referred to the volume *Exploring the Base for Family Therapy*[44], and to the publications of Bowen[45], Wynne *et al.*[46], Ackerman[47], Bateson *et al.*[48], Jackson[49, 50] and Jackson & Weakland[51], and Laing[52], principally though not entirely in the field of schizophrenia. Further contributions have come from Bell[53], MacGregor[54], Sonne *et al.*[55], Boszormenyi-Nagy[56], Haley[57], and Weakland[58].

An attempt must now be made to illustrate its relevance to the problems in asthma research just discussed:

(i) *Dilution of 'observer influence'*. Experience of the conjoint approach with families having a schizophrenic or delinquent member shows a radically different interview situation from that of individual therapy. Family interaction patterns, though initially stilted by the strangeness of the situation, usually rapidly assert themselves. Typical family relationships are soon revealed, and in a diagnostic setting, where the observer is either behind a viewing screen, or if present is not striving strenuously to intervene *qua* therapist, the mutual 'arousal' and interpersonal monitoring that goes on yields extremely rich verbal and non-verbal 'material'. The interactional contribution from the observer is diluted greatly; his presence is not irrelevant but it can be reasonably portrayed as contributing to an interactional situation which is a paradigm of the complex relationship of the family with the outside world—a world which can be charitable, is more often felt to be hostile, and because of this ambiguity is inevitably confusing and therefore a constant challenge. This clinical setting cannot be the *natural* family state, if by this is meant a sense in which it can be self-contained in isolation. But it is very doubtful whether such a conception has any real validity. In any case it is here claimed that the family interview,* observed and recorded, is the only way we have of putting the understanding of family interaction on a scientific footing. With the above qualifications the setting provides, as suggested in a recent paper of mine[59], a more or less direct view of the family interactional basis of his personality structure (and maladjustment, etc.) as also that of his sibs, and of the parents as far as parent–child interaction reveals this. The setting encourages the giving of historically accurate data also, so that the picture of the development of the

* Home interviews perhaps closer approximate to the natural state, but the *interviewer is still a factor*, and the situation is less amenable to observation and recording.

family environment has a welcome reliability. The effect of social 'input' gauged from the families' discussions of wider communal contacts can be discerned too.

In short, a considerable range of each individual's capacity for interaction is quite rapidly seen, which includes unexpected positive and creative potential in the 'patient', as well as sick aspects of the 'healthy' members.

Given a satisfactory technique for data collection to enable ready comparison amongst a series of patients and their families, the conjoint family approach would seem clearly appropriate to the study of the asthmatic child or adolescent.

(ii) *The search for meaningful data*. Particularly helpful here have been the writings of Haley[60, 61] on the nature of symptomatic behaviour. On the basis of some earlier ideas elaborated jointly with the other members of the Bateson group[48] he has shown how understanding of the multi-levelled nature of messages allows systematic description of relatively brief sequences of communication. Further, he has shown in what may loosely be termed 'control theory', how 'sick' messages (e.g. of a double-bind nature) denote 'sick' relationships.

Subsequently Jackson, Riskin & Satir[62], using these and other concepts, have demonstrated considerable accuracy in identifying pathology from 'blind' study of short excerpts of unfamiliar tape-recorded family therapy sessions.

Hope is held by these workers that a 'typology' of families can be worked out, based on the classification of their communication patterns, which will add a new dimension to present orthodox categories of psychopathology. The close study of interaction is a source of data as compact as that utilized by current psychometric tests and, in a sense, ontologically more directly meaningful. At the same time the data comes from the very soil in which psychoanalysis is grounded—whether or not this is openly acknowledged—i.e. family events and their significance for the communications of the individual.

(iii) *The nature of 'sickness' and 'health'.* Little further can be said on this question. It is unlikely that philosophic and cultural obstacles to agreement in this area will ever be fully overcome. However, just as psycho-analysis has significantly increased our understanding of human behaviour, so the fresh approach of family therapy may add new insights still. It could, for example, be important if personality assessments of 'asthma family' members using psychometric tests clashed consistently with those gained in family therapy situations. The basic presuppositions and 'norms' of the former would be one of the variables requiring serious re-examination.

*   *   *

Bearing in mind now the material considered throughout this paper, it remains merely necessary to enumerate the general ways in which research employing the conjoint family approach might eventually be found to fulfil a useful function with respect to bronchial asthma. Clearly a variety of research programmes would be needed to survey these topics at all adequately.

(1) Shed fresh light on the question of personality disturbances in the patient and family members; furnish material for comparison with assessments using accepted psychometric techniques. Should this comparison yield obvious discrepancies, a need will be shown to check the basic assumptions of both the family approach and of the psychometric procedure (its 'norms', etc.).

(2) Provide opportunity for a dynamic formulation of the family milieu, especially with respect to the role of the asthmatic attacks in family interaction and in the maintenance of family homeostasis. For example, would the onset of an attack be predictable in certain conflictful situations?

(3) Provide historical evidence whether or not disturbances in family interaction antedated, in some degree, the patient's asthma; enhance understanding of *how* the asthma further exacerbates these problems.

(4) Provide a cross-check on the significance of differences discovered hitherto between 'asthmatic families' with a heavy, slight, or non-existent loading of allergy.

(5) Lend evidence to help support, or refute, a 'learning process' mechanism for asthma; specifically this would involve tracing historical situations in which conditioning processes, either for emotional or allergic factors, might have been initiated and subsequently reinforced.

(6) Provide an evaluation of the method as a treatment adjunct for the patient's asthma, and as a more definitive therapy for psychological problems in all the family members. Experience with other conditions shows that where therapy is being successful, this is inseparable from a general movement toward health in the family as a whole.

Some of these aims are currently being incorporated into the planning of a pilot study on asthmatic children and their families. This hopefully will lead to the construction of more organized and sophisticated propositions for comprehensive research later.

The field of psychogenesis in asthma is seen here to be a large and formidable one, especially now as widening 'psychosomatic' horizons and new methodologies exceed in many cases the experience of any individual worker and tax his conceptual abilities to (or beyond!) their limits. Furthermore, humility is clearly a good companion when one notes the arresting and sobering reflexion that: 'All of us in science are at the mercy of our prejudices. If you happen to have the right prejudices they call it insight. If you have the wrong prejudices you're likely to be called a crackpot' [63].

SUMMARY

This paper investigates the present status of theory and research into psychological factors in the production of bronchial asthma. It describes how respiratory function is a sensitive indicator of emotion, and discusses the 'meanings' that have been attributed to asthmatic wheezing. Theories of the asthmatic 'personality' are mentioned, and the various

attempts to study his 'early environment' are described. With respect to the 'choice' of asthma as a symptom, the unlikelihood of two different kinds—'allergic' and 'psychological' —is discussed and the need for a unified theory of allergic and emotional factors recognized. Possibilities for a 'learning process' are suggested, with tentative mechanisms being outlined to link together emotional conflict, allergic reactivity and disturbed respiration. Central to the theoretical problems of asthma are the diverging views about 'personality' and 'early environment'. It is contended that inadequate recognition of the influence of the investigator in planning, performing and interpreting research is partly responsible, together with the lack of satisfactory ways of collecting meaningful data. Over-simple conceptions of 'sickness', based on inadequate understanding of 'health' are also possibly contributory. Conjoint family therapy is suggested as a new approach which might help shed light on several of the areas involved in an over-all understanding of psychogenesis in asthma.

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Group identification under conditions of external danger*

By IRVING L. JANIS†

It has long been known that when people are exposed to external danger they show a remarkable increase in group solidarity. That is, they manifest increased motivation to retain affiliation with a face-to-face group and to avoid actions that deviate from its norms. The importance of primary group factors was not fully appreciated until converging observations were made by psychiatrists, psychologists, and sociologists during World War II. These observations indicated that the average combat soldier's willingness to engage in hazardous combat duty depended largely on group identification. The term 'group identification', although not rigorously defined, has been used to designate a set of preconscious and unconscious attitudes which incline each member to apperceive the group as an extension of himself and impel him to remain in direct contact with the other members and to adhere to the group's standards.

In the present paper, I shall focus on a set of intriguing theoretical problems concerning the causes and consequences of group identification—problems which can be illuminated by examining situations of extreme danger. Why is it that exposure to external danger has such a marked effect on the solidarity of a face-to-face group? What are the preconscious and unconscious mechanisms that underlie the strengthening of group ties under conditions of danger? What are the favourable and unfavourable *consequences* of group identification?

My interest in these problems dates back to the last months of World War II. As psychologists in a morale research organization of the U.S. Army, my colleagues and I conducted a large number of intensive interviews with American combat soldiers in the European Theatre. Time and again we encountered instances when a man failed to act in accordance with his own self-interests in order to ward off separation fears or guilt about 'letting the other guys down'. For example, soldiers who had performed well in combat sometimes refused to accept a promotion if it entailed being shifted to another group. Men who were physically ill, or suffering from acute anxiety symptoms, avoided going on sick call and struggled against being withdrawn from combat because they did not want to be separated from their unit. Severe casualty cases, after being sent to a hospital in the rear, developed intense guilt feelings concerning their comrades at the front and sometimes went A.W.O.L. from the hospital or replacement depot in order to return to the front in an attempt to rejoin their comrades.

During the year and a half following the end of the war, the opportunity arose to check my observations against the findings from a variety of other sources of morale data, while working on a large social psychological study of World War II, in collaboration with Samuel Stouffer and others. This collaborative work, which was subsequently published in a volume entitled *The American Soldier: Combat and its Aftermath* (1949) is one of the main sources of empirical data on the behaviour of combat groups used in preparing the present paper. I have also examined carefully the extensive psychiatric literature bearing on emotional aspects of the behaviour of combat soldiers, including some reports about those in the British Army and German Army as well as the American Army.

In formulating hypotheses about the causes and consequences of group identification,

I have also taken into account parallel phenomena on group solidarity encountered in my research investigations on the way people react when they are facing objective threats of body damage and annihilation. One investigation, reported in a book on *Air War and Emotional Stress* (1951) involved surveying the existing evidence on civilian reactions to wartime dangers during World War II. A more recent series of studies published a few years ago in a book on *Psychological Stress* (1958) was focused on psychological aspects of *surgery* and was based on my psychoanalytic observations as well as behavioural studies of surgical patients.

My formulations and illustrations concerning group identification in the present paper are based mainly on the studies of surgical patients and the studies of wartime danger situations. However, most, if not all, of the hypotheses seem to be applicable to *any* face-to-face group that is exposed to *any* common source of external stress. One of the values of concentrating on group behaviour under the conditions of extreme physical danger is that we can sometimes see quite clearly the manifestations of basic psychological processes. The same processes may occur in a much more subtle form in the group behaviour of people who face the common threats of everyday social life, such as loss of esteem from fellow workers or friends, disapproval from one's employer, and all the various signs of potential failure, humiliation, and loss of status that typically give rise to social anxiety in clinically normal people.

Most of the hypotheses to be presented are based on psychoanalytic theory and make use of concepts derived from clinical psychoanalytic observations. Scattered throughout the extensive psychoanalytic literature on ego ideals, super-ego functions, object relations, and related topics, there are numerous case study observations that seem relevant for specifying the unconscious determinants of group behaviour in normal, as well as neurotic, adults. Major sources for such material are Freud's classical contributions to group psychology. Flugel's monograph on *Man, Morals and Society* (1945) and Fritz Redl's studies of antisocial adolescent gangs (1942, 1957).

The hypotheses I have singled out are ones that appear to be highly plausible in the light of the existing evidence. But, since the observations come primarily from studies of extreme danger situations, it must be emphasized from the outset that we cannot be at all certain about how far these hypotheses can be generalized. Perhaps some of them apply only when there is actual danger of annihilation combined with a host of severe deprivations of the type seldom encountered by anyone except in wartime. All such questions concerning the verification and generality of the hypotheses obviously must remain open until more systematic evidence becomes available from further research.

TRANSFERENCE REACTIONS

According to Freud's (1922) theory of group behaviour, much of the motivation for group solidarity comes from the strong emotional bonds established between each member and the leader. Freud speaks of 'transference' reactions toward the idealized leader who, as a parent surrogate, provides the main impetus to a group for sharing common ideals and standards of conduct.

Certain regressive features of unconscious transference reactions toward authority figures become quite apparent whenever one observes people who are exposed to severe reality dangers, especially when there is a threat of mutilation or annihilation. I have been strongly impressed by manifestations of unconscious dependency needs not only among combat soldiers but also among civilians when they are exposed to the warnings of wartime bombing attacks or peacetime disasters, or to the more personalized threats of illness and surgery. One of the main hypothetical constructs which seems to be useful in accounting for the upsurge of these dependency reactions is the *reactivation of separation anxiety*. We know, of course, that exaggerated fears of being abandoned by the parents arise early in

life, especially on occasions when the child feels ill, injured, or unable to escape from threatened pain. Such fears persist in latent form in adulthood and underlie the characteristic changes in the social behaviour of persons exposed to danger: they show increased interest in establishing close affiliation with any available primary group and they *seek to be reassured that the significant persons in their lives will not leave them or break preexisting affectionate ties.* This fear-ridden type of dependency is likely to develop toward any authority figures who are perceived to be in a position to increase or decrease their chances of warding off the danger. I refer to such persons as 'danger-control authorities'. These authorities tend to be over-idealized and misperceived in a variety of ways, under the influence of deep-seated attitudes and expectations derived from early life experiences. Here I refer mainly to those experiences in which one or both parents had been perceived by the child as being responsible for the onset and termination of suffering and pain.

The manifestations of transference on the part of normal adults who face serious external dangers are remarkably parallel to those shown by psychoneurotic patients undergoing psychoanalysis, especially during critical periods of treatment when the analyst becomes momentarily an authority figure to whom the patient's own superego functions have been assigned (cf. Sandler, 1960, pp. 156–8). Persons in both types of situations overestimate the power of the authority figure and become pre-occupied about whether his intentions are good or bad. They also become extraordinarily sensitive to his demands, continually attempting to do and say things that will please him, reacting with bitter disappointment at any apparent slights, and becoming depressed or aggrieved whenever they are not in communication with him.

In addition to the foregoing dependency phenomenon induced by reality threats, the propensity to develop affectionate ties with an authority figure and with comrades is probably augmented whenever a group is socially isolated. For example, soldiers in combat are far removed from their parents, siblings, and all those other persons back home who may have played a significant role in satisfying their emotional needs. Similarly, patients in a surgical ward are separated from their families and friends except for rather brief visits. Transference reactions, under these conditions, become a matter of psychological *replacement*, an unconscious means of enabling the missing family members to become symbolically present. Thus, the company commander or the surgeon is likely to become a symbolic representative of the father, and a fellow soldier or fellow patient may become a substitute for an older or younger brother. The individual will then unconsciously respond to the parent substitute and the sibling substitute in some of the same ways that he used to respond to the original object.

If this unconscious substitutive process occurs at a time when external dangers foster strong dependency needs, the individual is especially likely to undergo a partial regression in his dealings with the surrogate persons. This entails what Erik Erikson has described as a 'blurring of an adult relationship through the transfer upon it of infantile loves and hates, dependencies, and impotent rages' (1957, p. 94).

Perhaps the most essential feature of transference from the standpoint of group dynamics is the tendency to overestimate the power of the surrogate person, which heightens sensitivity to his expressions of approval and disapproval. When a conscientious officer is unconsciously regarded as a father surrogate, the men under his command will be strongly motivated to accept his orders and to adhere to the group standards, if only to maintain the approval of a man who is now endowed with the attributes of a significant authority figure from the past.

REASSURANCE NEEDS

Next we shall consider additional *needs for reassurance* that are directly stimulated by external danger and that are satisfied through interaction with fellow members of the primary

group. Studies of combat soldiers provide exceptionally rich material on this aspect of group psychology.

In morale surveys during World War II, we found that many soldiers said they would not want to be shifted to any other unit because they felt *safer* with their own group. For example, a wounded veteran of combat in North Africa said: 'The fellows don't want to leave when they're sick. They're afraid to leave their own men—the men they know. Your own outfit—they're the men you have confidence in. It gives you more guts to be with them'.

Now when a soldier says that 'it gives you more guts' to be with the men in your own outfit, it is not merely because of the increase in actual protection he consciously anticipates. External threats foster increased reliance on the group by arousing a variety of basic psychological needs for reassurance, some of which are, of course, preconscious, or unconscious.

At least temporary emotional relief seems to be obtained not merely from the occasional serious discussions in which the men implicitly promise to 'stick by' each other in the event of injury or dire need. They also tell each other jokes and tall stories about how badly things are going; they exchange banter concerning their poor chances of survival; and they engage in many other forms of 'kidding around' that are heavily tinged with gallows humour.

Whether serious or humorous, these informal interchanges among members of a combat team probably touch off a number of different reassurance mechanisms, all of which can contribute to the alleviation of fear:

1. From the affective expressions as well as the content of his team-mate's comments, the individual soldier can quickly come to realize that they must be suffering from essentially the same worries, longings, and conflicts as himself. The damage to a man's self-esteem is minimized by the opportunity to perceive that other men are equally frightened—that they too have strong wishes to escape from hazardous assignments, and are equally unsure of their own capacity to live up to the masculine ideals of not being a 'sissy'.

2. By openly expressing his private fears and confessing his weaknesses to one or more empathic listeners, the individual may gain emotional rapport similar to that occurring in the early sessions of psychotherapy. Here the crucial factor may be the permissive social atmosphere of the work group, which provides an opportunity for mutual self-revelations with relatively little danger of being censured or humiliated.

3. When a man airs his private fears and grievances he will sometimes elicit comments from others which have a corrective effect on his appraisals of the external dangers. The more experienced combat veterans, despite their general proclivity for conveying a very black picture, would often 'wisen up' the green replacements in their units. For example, many men entered combat with vague paranoid-like fears about the possibility of being shot by their own military authorities, partly because they thought this would be the prescribed punishment if they were to fail to carry out a suicidal mission ordered by an uninformed or inhuman commander. But combat soldiers in the U.S. Army gradually came to realize that in actual practice offenders were not executed. The popular notion that American combat men were facing a choice of possible death from the enemy versus certain death if they refused to fight was a grossly unsubstantiated myth. Informal group discussions between fresh replacements and the more experienced members of the combat team probably served a reality-testing function, exploding such myths and correcting other exaggerated notions about the dire consequences of deviating from military regulations, as well as clearing up misconceptions about the strength of the enemy and about the devastating power of the enemy's weapons.

4. When a soldier knows that his group is facing severe danger and that his own life as well as the lives of his comrades are at stake, he becomes extremely sensitive to being treated impersonally, as a mere cog in a machine. In military service, however, it frequently happens that the men in operational units are subjected

to seemingly arbitrary and impersonal treatment by officers in higher headquarters. During World War II, for example, a high percentage of combat men, after having spent weeks or months in overcrowded replacement depots, felt they had been badly 'kicked around' by the military organization and were acutely aware of being treated as an expendable item. By becoming an accepted comrade the individual soldier can counteract, to some extent, the disturbing perception of himself as a *passive victim* at the disposal of an impersonal military organization whose high officers can make drastic decisions with little or no regard for the value of his life. The attractiveness of the local work group becomes greatly enhanced as the individual encounters the first acts of friendship on the part of his team-mates and immediate superiors, which reassure him that he *still counts as a person*. Moreover, once the men begin sharing their feelings about the Army organization, they soon acquire the illusion that the work group has the power to see to it that its members will not be neglected or maltreated by higher headquarters.

In so far as the soldier's needs for reassurance are satisfied by interpersonal relationships with his comrades, he becomes strongly dependent upon his work group to counteract his dysphoria. Thus the individual becomes strongly motivated to behave in such a way that the others will continue to accept him as a member in good standing. The threat of the group's disapproval or rejection, therefore, becomes all the more effective in suppressing any inclinations to deviate from the group norms.

The 'sharing of fear' in combat units—in the many different forms which have just been described—probably enables many soldiers to adapt to severe stresses that they otherwise might not be able to withstand. In *Psychological Stress* (1958), I have reported similar phenomena from studies of surgical patients. The evidence from these studies strongly suggests the following general proposition: when a person's anticipatory fears have been stimulated to a *moderate* degree before being exposed to actual stress stimuli, there is less likelihood

of his being overwhelmed, or becoming resentful toward danger-control authorities, than if his anticipatory fears have *not been at all stimulated* during the precrisis period. For the purpose of conceptualizing the normal processes of inner psychological preparation, I have introduced the term 'work of worrying', as a construct analogous to the 'work of mourning'. The work of mourning usually begins *after* object loss has occurred, whereas the work of worrying starts *before* a blow strikes, as soon as a person becomes convinced that he is facing a potential danger or loss.

The same book contains a detailed account of various situational factors (such as exposure to accurate warning information from an authority figure) that help a person to go through all the steps involved in completing the work of worrying and a number of hypotheses are presented concerning the ways in which this type of inner preparation can enable a person to adapt more adequately to a painful reality situation (Janis, 1958, pp. 359–94). For the present, it will suffice to call attention to the likelihood that the opportunity to talk about one's fears in a permissive group setting—and the opportunity to hear the members of the group verbalize fears similar to one's own—may have a long-range prophylactic effect. In other words, sharing one's fears with others may facilitate the development of adaptive defences and thereby reduce the chances of being traumatized if one is subsequently exposed to the actual harassments of severe danger.

MOURNING AND INTROJECTION

We turn now to a major source of military stress, which sets in after the emotional ties to the leader and to other members of the face-to-face group have become firmly established —namely, the repeated loss of buddies and of a succession of leaders who are members of the combat soldiers's 'family circle'.

When a combat unit sustains casualties, a number of readjustive mechanisms can be discerned among the survivors, which appear

to counteract group demoralization. One such mechanism involves unconscious identification with the men who had become casualties. As is frequently observed in psychoanalytic studies of civilian cases, the mourning soldier uses the mechanism of 'introjection' to build up a substitute object within himself. In one way or another he changes his behaviour to resemble the lost object. The characteristics taken over by the mourner, of course, include moral standards and ego ideals as well as physical characteristics. Fenichel (1945) asserts that this process of introjection is a normal component of mourning, becoming a pathological depression only when it involves a prolonged period of 'regression to orality', with a predominance of sadomasochistic tendencies that go beyond an attempt merely to undo the loss. (I shall return to the problem of pathological mourning later on.)

Psychoanalytic studies of 'normal' reactions to the loss of a father figure indicate that the post-bereavement identification entails much more compulsive conformity with the standards of the man after he is dead than when he was alive. Flugel (1945) points out that a live parent figure can be influenced by the individual into giving his approval to new patterns of behaviour, and thus the internalized code need not be inflexible when new circumstances are encountered; but, when he is no longer alive, he cannot be persuaded or cajoled into giving his approval, nor can he offer forgiveness for minor deviations from his standards. Flugel says: 'What psychoanalysts have sometimes called "postponed obedience" to dead parents may be a harder discipline than obedience to a living parent' (1945, p. 188).

In a closely knit combat group, the same type of 'postponed obedience' seems to occur following the loss of a leader or comrade. An unconscious form of attitude change occurs which has the effect of markedly increasing adherence to all those group norms which were manifestly valued by the dead man. To a lesser extent, the same type of compensatory attitude change is to be expected when a leader

or comrade has been removed from the unit because of a promotion to a new position of greater responsibility.

The foregoing comments about mourning reactions suggest that the blood price paid by units in active combat may contribute a powerful unconscious source of motivation to group conformity. However, there is a compulsive quality that characterizes the conformity behaviour arising from introjection, which might sometimes interfere with the effectiveness of group performances. It is necessary, therefore, to examine the unfavourable as well as the favourable consequences of introjection and to attempt to predict the conditions under which the alternative consequences are likely to occur.

REACTIVE DEPRESSION AND THE 'OLD SERGEANT'S' SYNDROME

One clear-cut type of adverse reaction which has been repeatedly reported pertains to the small percentage of combat personnel who developed a pathological form of depression. Like the normal mourner, the depressed soldier seems to be attempting to undo the loss and to keep the missing person symbolically present: but he becomes almost exclusively preoccupied with these efforts, showing little or no interest in any aspect of his daily life. There is a well-known set of incapacitating symptoms of anxiety-mixed-with-depression which has been labelled the 'old sergeant syndrome'. (This name was used because the most striking cases occurred among non-commissioned officers who were old in combat experience.) The syndrome consists of a progressive deterioration in attitudes and performance, including a gradual decrease in mental efficiency, loss of self-confidence in ability to cope with danger, withdrawal from current social activities, apathy, and intense guilt feelings. According to Sobel (1947), who has given the classical account of it, this syndrome occurred during World War II in 'well-motivated, previously efficient soldiers, as a result of the chronic and progressive breakdown of their normal

defenses against anxiety in long periods of combat'. The same syndrome was observed in a high percentage of psychiatric casualties in combat divisions fighting in Korea during 1950–51 (cf. Glass, 1954).

The symptoms comprising this syndrome usually do not appear during the first month or two of combat, which is the period when group identification becomes intensified. However, as the subsequent months go by, and as casualties mount, friendships become sharply restricted to a few 'old timers' who started out together in the original unit. This restriction in the formation of friendship ties evidently arises because the battle veteran fears a repetition of the painful reactions he has repeatedly experienced when he lost his closest friends in combat. It is during this later phase that symptoms of chronic anxiety and depression make their appearance, insidiously developing into the 'old sergeant' syndrome. As more and more members of the original group become casualties, the survivors become more and more inhibited with respect to forming new attachments, precisely because they have developed an attitude of defensive *detachment* toward the here-and-now combat group. The old sergeant no longer perceives himself as an integral part of the entire fighting group, although he may retain a sense of identification with a few of its original members. The latter, however, are men who, like himself, have become apathetic, inefficient, and 'beat up'. As a result, his conception of the group no longer serves to bolster his self-confidence.

The fact that these men develop the classical symptoms of depression suggests that an unconscious process has occurred whereby they regress from object relations to a pathological form of incorporation. In order to account for this process, it is necessary to emphasize one aspect of the normal work of mourning that is often neglected, namely, the process of seeking for and finding *substitute persons in reality* who will replace the lost object.

In 'Mourning and Melancholia', Freud (1917) alludes to this process. When describing the pathological features of melancholia, he mentions in passing that *normal* adaptation to the loss of a cherished object involves not merely the withdrawal of cathexis from the lost object but also the *transference of cathexis to a new object*. This he regards as the normal pathway that is abandoned by the depressed patient, who reacts solely by incorporating the lost object into his own ego.

At the beginning of this paper, I introduced the assumption that the soldier's attachment to his leader and to others in his work group comes about partly as a result of the normal type of transference that enables him to replace his own absent family members and other loved persons he reluctantly had to leave behind. During the first few months of combat, this normal type of transference continues to take place to the surviving members of the group and leads to a heightened cathexis of the existing group. That is, the love and affection that had formerly been attached to the lost comrades is transferred to newcomers and to others in the existing combat group. Evidently, in order for this re-cathexis of the existing group to occur, the mourner must be able to seek and accept *substitute* objects in reality who will enable him to compensate for the lost gratifications and the lost emotional ties. But then the substitutes, in turn, are lost— often at a time when the work of mourning for the first lost object is not yet complete—and so a new painful loss is added to the original one. The mourner then seems to become wary of finding any new substitutes and begins to show a self-preoccupying process of identification with the dead.

This pathogenic development seems to involve a regressive process that could be considered as a form of *reactive narcissism*. I suspect that two sources contribute this reaction. First, the loss of comrades through injury and death may be unconsciously equated to being *abandoned* by them at a time when they are sorely needed. Case studies of surgical patients strongly suggest that, in a situation of prolonged stress, the absence of any affectionate person (no matter how legitimate or excusable his absence is known to be at the conscious

level) will unconsciously tend to reactivate childhood episodes of profound grief in which the parent's temporary absence during a period of illness or suffering was experienced by the child as an abandonment. Secondly, the longer the duration of suffering and deprivation, the greater the likelihood that the leader and other members of the group will be unconsciously perceived as failing to use their power to terminate the suffering. In effect, like a small child, the sufferer gradually becomes more and more angry at those he feels are supposed to protect him from harm because they haven't yet made the enemy—or any of the other bad things—go away. These two factors—the repeated *loss* of members of the group combined with prolonged *continuation* of danger and suffering—give rise to an aggrievement reaction. This reaction heightens the intensity of the individual's ambivalence toward the remaining members of the protective group, which probably sets in motion the regressive process, fostering the more pathological form of introjection that we see in the old sergeant syndrome. As Freud puts it, 'the conflict due to ambivalence gives a pathological cast to mourning and forces it to express itself in the form of self-reproaches to the effect that the mourner himself is to blame for the loss of the loved object, i.e. that he had willed it' (1917, p. 251).

DELINQUENT BEHAVIOUR

The remainder of this paper will be devoted to another type of unfavourable consequence of group identification—mutual support for delinquent behaviour. Freud and other psychoanalysts have pointed out that war conditions tend to create a 'war superego' in soldiers, which is a type of auxiliary superego that permits the men to express a variety of impulses ordinarily held in check, thus overriding the 'normal peace ego'. In his book on *Group Psychology*, Freud states:

For the moment it [the group] replaces the whole of human society, which is the wielder of authority, whose punishments the individual fears, and for whose sake he has submitted to so many inhibitions. It is clearly perilous for him to put himself in opposition to it, and it will be safer to follow the example of those around him and perhaps even 'hunt with the pack'. In obedience to the new authority he may put his former 'conscience' out of action, and so surrender to the attraction of the increased pleasure that is certainly obtained from the removal of inhibitions (1922, p. 85).

We know that the members of a highly cohesive group sometimes support each other in ignoring authoritative demands from outside the group and participate in delinquent actions without experiencing the intense feelings of social anxiety and guilt that would obviously develop if each man were alone. Redl & Wineman (1957) have specified the following factors as necessary conditions for the 'contagious effect' of delinquent or countermores behaviour in a peer group: (1) an initiator must openly 'act out' in such a way that he obviously gratifies an impulse that the rest of the members have been inhibiting; (2) the initiator must display a lack of anxiety or guilt; (3) the other members who perceive the initiator's actions must have been undergoing for some time an intense conflict with respect to performing the forbidden act; i.e. they must have such a strong urge to commit the act that they were just barely able to inhibit its release prior to the initiator's demonstration. Thus, according to Redl & Wineman (1957) it is the sudden perception of fearless and guiltless enjoyment of what they have been longing to do that sways the members of a group to become psychologically infected by a delinquency-carrier.

While caught up in a group epidemic of delinquency, the members will commit sadistic and narcissistic acts that later on, after the atmosphere of shared excitement has subsided, evoke feelings of remorse, apprehension, and loss of self-esteem. Following any single episode of wayward group behaviour, the intensity of an individual member's dysphoric reaction and the degree to which his inhibitory controls are re-established will de-

pend partly on what the other members of the group do and say about it.

Psychoanalytic observers have called attention to the numerous ways in which the members of a cohesive group *share the guilt* so as to ward off or minimize their dysphoric reactions. 'Sharing the guilt' refers to a complex set of mechanisms whereby internalized standards are temporarily set aside or modified as a consequence of interaction with others in a primary group. Each member of the group experiences some relief from knowing that 'I am not the only one who did it'. Fenichel (1945) assumes that this relief occurs as a result of a 'quasi-projection' mechanism: a guilty person who places the blame on his entire group is displaying an attenuated form of projection ('all of us did it, not just me'). This involves much less distortion of reality than the more extreme projections in which the blame is placed entirely on other people ('they are responsible, I had nothing to do with it').

In addition to a quasi-projection mechanism, it seems to me that there are other psychological processes which also enter into the sharing of guilt:

1. Denial of dysphoric affect and reaction formations against guilt are probably facilitated when the group members openly communicate to each other a manifest attitude of tough-minded indifference concerning immorality, especially when everyone continues to act as though he accepts at face value the carefree manner with which moral scruples are being ignored.

2. In a group atmosphere where the members are speaking nonchalantly about the morally objectionable things they have done, there are frequent opportunities for a surreptitious form of confession, for those who are seeking to unburden themselves of unacknowledged guilt.

3. Seeing and hearing others in the group talk unembarrassedly about participation in a collective spree can also have the effect of reinforcing an illusory belief of ethical validity '(it must be O.K. if everyone else admits doing it'). And, at the same time, it also fosters an illusory sense of being protected against the power of the punitive authorities ('we're all in this together, so they can't punish any of us').

4. After collectively committing serious acts of violence, the members' retrospective accounts to each other may help them to arrive at a convincing set of rationalizations to exculpate themselves. For example, they can excuse the damage they created by agreeing that 'it was an accident'. Or they can justify themselves for maltreating innocent victims by developing the shared belief that 'they had it coming to them'. A major type of guilt-evading rationalization that seems to be especially common both in military units and in adolescent gangs is the belief that one's own offences are excused if some other person was the initiator of the forbidden behaviour: 'We didn't start it so we're not responsible.'

From what has already been said it is apparent that intra-group communications can facilitate the formation of rationalizations in two ways: first, since the members share a common need for finding excuses for the offence, they can *pool their inventive resources* to arrive at a much better case for themselves than any one person would be able to think up himself; secondly, when all members show signs of accepting any alleged explanation for the offence, their *unanimity lends authenticity* to the excuse, furnishing the same type of consensual validation that is commonly accepted by most people as grounds for believing explanations about impressive events in their daily lives. ('If everyone says so, it must be true.')

In this connexion, it is important to note that the same group influences that enable scrupulous men to overcome their inhibitions and become 'good' soldiers may, later on, lead to their becoming 'bad' soldiers and 'bad' citizens.

The combat soldier is required to overcome his internal restraints against violent acts and, in order to do so, he relies more and more upon the support of the combat group. As inner

controls based on personal conscience become partially replaced by outer controls based on signs of group approval or disapproval, the members are likely to support each other not only in connexion with the release of hostility toward the enemy but with respect to other forms of gratification as well. For example, if the members adopt an informal code of regularly maltreating captured soldiers, and share the same rationalizations for warding off the accompanying guilt feelings, it becomes an easy step to accept and rationalize similar maltreatment of enemy *civilians* (e.g. 'They have it coming to them for all the atrocities their side has committed against our side.') The least inhibited member of the military group then feels quite safe in initiating new forms of countermores activity in captured towns—such as looting private homes, misusing military food supplies to force old people to give up their jewellery or other hidden possessions, and applying pressure on young women to submit sexually. A contagious effect is then likely to occur among the other men in the unit, who have also been longing to obtain the same types of gratification during the long periods of extreme privation. As each man participates in more and more antisocial behaviour, an acculturation process takes place, so that the inhibitory power of his former moral scruples is increasingly weakened.

The military group, then, serves an *initiating* function, in that it provides powerful incentives for releasing forbidden impulses, inducing the soldier to try out formerly inhibited acts which he originally regarded as morally repugnant. In addition, the military group furnishes a social milieu which *facilitates the unlearning of inhibitions*. It is especially in connexion with the latter function that the various mechanisms of sharing the guilt enter in. With the help of the other men in his unit, the soldier who is burdened with guilt following a first violation will gradually take over the group-sanctioned rationalizations, projections, and reaction formations that enable his guilt to subside to a relatively low level.

FACTORS FOSTERING A DEVIANT INFORMAL CODE

When we examine the various documented instances of military violations on the part of local units, we obtain some clues pertinent to the following general question, which has considerable practical as well as theoretical implications: *Under what conditions will a cohesive local group provide mutual support for violations of the norms of the superordinate organization with which it is affiliated and develop an informal code of its own that opposes the organization's code?*

One major factor that must be taken into account was implied in my earlier statements about transference, namely, the attitudes conveyed by the local leader. Obviously, when a primary work group has a leader who openly opposes the demands of the organization, the chances are greater that the group will develop an informal code that deviates from the organizational norms. However, it is unwarranted to assume that a group of soldiers is wholly passive with respect to accepting a local leader's influence. If an officer encourages his men to perform acts that are extreme violations of the rules of the military organization—for example, shirking a dangerous assignment, engaging in looting, or selling military supplies on the black market—the group members may reject his demands and spontaneously turn to an informal leader who induces much less conflict. Thus, it is essential to examine the influence of a local leader with anti-army attitudes in relation to other factors that also enter into the picture when the members of a local unit undergo a conflict of the type under discussion.

Taking account of observations bearing on dissident behaviour in industrial and political organizations, as well as the military studies already cited, I shall now attempt to draw some inferences concerning the conditions under which the members of a local group will mutually support each other in repeatedly violating the organization's norms. A number of important factors can be discerned, which

appear to be major determinants of delinquent behaviour in situations where the members of a military unit mutually support each other in taking advantage of opportunities for shirking their duties, for seeking personal aggrandizement, and for indulging in antisocial sexual exploits.

The following four conditions seem to be the most obvious antecedents of persistently deviant behaviour on the part of a local unit: (1) most men in the unit have specific grievances against the superordinate organization, and feel resentful toward the top leadership for neglecting their needs, for inflicting unnecessary deprivations or for imposing extraordinarily harsh demands which menace their personal welfare; (2) the members perceive their group as having no channel open for communicating their grievances to the top levels of the hierarchy or are convinced that such communications would be wholly ineffective in inducing any favourable changes; (3) the organization is perceived as having little or no opportunity for detecting the deviant behaviour in question; and (4) one or more central persons in the local unit communicates disaffiliative sentiments to the others and sets an example, either by personally acting in a way that is contrary to the organization's norms or by failing to use his power to prevent someone else in the same group from doing so.

The psychological conditions just described could be seen quite clearly among American occupation troops stationed in disorganized German cities at the end of the Second World War. I encountered a series of extreme examples in a study (1945) conducted among American infantrymen stationed in Berlin during the summer of 1945, at a time when the entire population was suffering from an acute food shortage. Both the interviews and direct observations indicated that a very high percentage of the men were violating military regulations (and the moral code of their society) in taking advantage of their economic power over the starving Berliners. Most of the American soldiers were regularly pro-

fiteering on the black market (e.g. exchanging a few candy bars for a Leica camera) and were openly purchasing sexual partners (e.g. soliciting girls at public places by holding up a can of C-rations or a candy bar). The men who had been stationed in Berlin for less than ten days appeared to express more guilt feelings about exploiting the hungry civilians than the men who had been on occupation duty in Berlin for a longer period of time. At night in the barracks there were bull sessions in which one could observe the ways in which they were 'sharing the guilt'. In their group discussions, the men encouraged each other to continue seeking out the rare opportunities afforded by being stationed in the starving city and spoke about the 'reasons' why the German people deserved to be mistreated and why much of the blame for their exploitation could be placed on the Russian occupying forces, whose mistreatment of the Berliners in the eastern zone was said to be far worse than the Americans'.

Much of the exploitative behaviour was instigated by combat veterans, who felt that they had already done more than their share and were resentful about not being sent back to the United States promptly. Furthermore, the men perceived themselves as being isolated to an unusual degree from the main headquarters of the U.S. Armed Forces in Europe (especially since they knew that the western sector of Berlin was only a small island in Russian-controlled territory). The social disorganization that characterized the entire city was such that most American soldiers felt there was little chance of being detected in black marketeering or in other illegal activities by the Berlin police, by the U.S. military police, or by any authorities in the U.S. Army. It is not known to what extent the leaders of the local units actually encouraged the men to indulge in illegal activities, but there is little question that the non-commissioned officers, and to some extent the commissioned officers, actively participated in such activities themselves. Thus, it seems likely that all four conditions were present and contributed to the

longer a supposed temporary repugnance but a refusal of food that may be indefinitely prolonged.

The disease is now declared and so surely will it pursue its course that it becomes easy to prognosticate the future. Woe to the physician who, misunderstanding the peril, treats as a fancy without object or duration an obstinacy which he hopes to vanquish by medicine, friendly advice, or by the still more defective resource, intimidation (p. 265). With hysterical subjects a first medical fault is never reparable, ever on the watch for the judgements concerning themselves especially such as are approved by the family. They never pardon, and considering that hostilities have been commenced against them, they attribute to themselves the right of employing these with implacable tenacity. At this initial period the only prudent course to pursue is to observe, to keep silent and to remember that when voluntary inanition dates from several weeks it has become a pathological condition, having a long course to run (p. 265). If I attach to this mental condition an importance that perhaps will appear exaggerated it is that in fact the whole disease is summed up in this intellectual perversion (p. 368).

He continues:

The appearance of these signs (amenorrhea, constipation, etc.), the import of which can escape no one, redoubles anxieties and the relatives and friends regard the case as desperate. It must not cause surprise to find me always placing in parallel the morbid condition of the hysterical subject and the preoccupation of those who surround her. These two circumstances are intimately connected, and we should acquire an erroneous idea of the disease by confining ourselves to an examination of the patient (p. 368).

Summarizing these descriptions for the purpose of giving the essential features of the syndrome anorexia nervosa, I would like to call your attention to the following points. First, the disease is found mainly in girls at puberty or post-puberty. Secondly, the refusal of food and self-starvation is psychologically caused. Thirdly, vomiting, spontaneous or self-induced, is frequent. Fourthly, amenorrhea might be the first symptom or it might occur as an obligatory symptom later. Fifthly, constipation is predominant.

The patho-physiology of these cases is similar to the ones found in chronic starvation. Although there is similarity with regard to the somatopsychic chains of events between anorexia nervosa cases and chronic hunger from exogenic causes, there are important differences. It is remarkable to see these emaciated girls always on the move. The borders of the syndrome can be drawn sharply enough to justify the diagnostic labelling anorexia nervosa. There is still a lot of confusion between anorexia nervosa and hypopituitarism, or pituitary insufficiency or Simmonds's disease because the illuminating English and French observations by Morton, Gull, and Lasègue either fell into oblivion or did not reach the medical public. On the other hand, anorexia nervosa has many connexions with all kinds of psychopathological states from hysterical lumps in the throat, depression to schizophrenia leading to secondary anorexia. This gives rise to the possibility of another erroneous diagnosis, namely, that of considering every serious loss of appetite and weight in psychiatric conditions as anorexia nervosa (cf. Bliss & Branch, 1960). I think that these comments are sufficient to make us aware of the borders of the syndrome. I would like to add one diagnostic observation. The negativism of these patients, the way they deny the seriousness of their state and their obstinate refusal to accept help is outstanding and typical. This behaviour has, of course, very practical consequences. The more seriously ill patients, especially, deny being in danger at all even after a loss of weight of up to 50 %.

In the psychoanalytically oriented studies on anorexia nervosa at the Psychosomatic Hospital of the Heidelberg University, we were quite careful to exclude all atypical cases. I would like to say a few words on the development of this investigation. At the beginning it was not planned as a clinical research. This hampered the follow-up studies. Because for the first cases we did not lay down a psychodynamic formulation and prognostication. We realized only gradually what an interesting subject anorexia nervosa is. There has been no psychiatric school in modern times which

has not attempted to explain and to understand this syndrome. I found it extremely stimulating to make a comparable investigation of various therapeutic approaches, starting from Morton's treatment by fresh air and ass's milk to leucotomy. No less thought-provoking are the different theoretical accounts of the illness.

In a monograph on anorexia nervosa (Thomae, 1961) we could include thirty cases which were admitted to our Hospital by 31 December 1959. At that time the Clinic had been functioning for roughly 10 years. Unfortunately, eleven cases of anorexia nervosa, some of which had been in psychotherapy for quite a time, could not be included because the case notes were insufficient. We have traced these eleven cases as carefully as possible. I am sure our therapeutic, prognostic and theoretical views on anorexia nervosa would be the same, if those eleven cases were included.

The sum total of examined and treated patients by December 1959 and covering 10 years was forty-one. In the meantime, that is since January 1960, we have seen about twenty more cases who were examined and most of them treated by intensive psychotherapy. After admitting that eleven cases have been excluded here, I am glad to say that we learned quite a lot during these years. This is borne out by the fact that we were more successful with the last twenty cases, both in overcoming the initial resistance of the girls and in the immediate treatment results. As most of these recent therapies are not concluded or, for that matter, follow-ups not practicable, I base the data on observations with the sample of thirty cases.

What is our typical anorexia nervosa patient like if one constructs such a being by taking the average of the most important clinical findings? She looks like this: At the onset the patient is 16½ years old, about 5 ft. 5 in. tall, and weighs about 121 lb. Menstruation started shortly before fourteen and amenorrhea has been one of the initial symptoms. When this average patient came into our hospital after being ill for 2½ years, her weight was down to 79 lb. The loss of weight amounted to about 42 lb., that is 34·3 %.

Of the thirty cases, seven had had no hospital treatment, fifteen had been once, five twice, two four times and one six times. The following diagnosis had been applied to these patients: eighteen times anorexia nervosa, three times Simmonds's disease, twice hypopertuitarism, twice depressive psychotic phase, once psychogenic reaction. This gives a favourable picture of the correct diagnostic labelling. A distinguished German endocrinologist regarded this as due to the special admission rate of a psychosomatic hospital. He still gets most of the cases diagnosed as Simmonds's disease. At any rate the diagnosis did not have favourable consequences as to therapy. Only three patients received psychotherapy, two of them for only a few weeks. All kinds of diets, partly insulin supported, electro-convulsions, combined hormone treatments and implantation of calves pituitary, were similarly unsuccessful. Largactil treatment as described by Dally & Sargant (1960) had not yet been introduced. The course of the illness after 2½ years was pretty much as described by Lasègue and as I quoted before.

Although Lasègue described beautifully the interaction of patient and family and patient and doctor, it needed the psychoanalytic method to recognize the importance of all kinds of subtle counter-transferences, or, should I say, counter-actions on to the process of the illness. Self-starvation and the patients' indifference towards their withering away automatically leads to emotionally regulated counter-reactions, depending on temperament and character of the doctor. It seems that there are more than a few doctors who go along with the self-deception of the patients and their relatives. On the other hand, the case histories and our own experiences with counter-transference reactions show how often attempts are made to cure the patient by sympathetic understanding or by strictness. Usually a struggle for power is established between the patient and her relatives, mainly her mother, and the doctor is similarly in-

volved. It seems that at least with more serious cases it is difficult to stand the anxiety stirred up by these self-starving girls without being provoked into counter-actions. We made it a rule, therefore, to have the patients supervized on the ward at the beginning of the psychotherapy. Only then can the level of anxiety on the doctor's part be reduced to a point where psychotherapy can be conducted. Of course, it is very important for the patient also to be hospitalized which implies being ill.

Perhaps it is helpful to sketch some of the typical danger points as we have observed them in our own doctor–patient relationships. It is not difficult to reconstruct from the literature that such an avoidable interaction perpetuates the illness. The denial of the patients seems to have a contagious effect: that is, people are inclined to belittle the state of affairs. Female colleagues tend to mother the patient. More sophisticated reasons for doing that can be found either in Margolin's anaclitic therapy (cf. Margolis & Jernberg, 1960) and its corresponding theory, or for more poetic sources in Kafka's *The Hunger Artist*. The 'hunger artist' says of himself that he is forced to starve himself and finally to die because he cannot find the nourishment which he is seeking.

I apologize for talking about such commonplaces as the importance of counter-acting and counter-transference, but the history of anorexia nervosa up to the present and our case histories show that the diagnostic and therapeutic implications of these faulty interactions are still insufficiently known, at least in Germany. Indeed, it is difficult to handle these problems, even when aware of them.

In our approach we took as our starting point some very simple questions, namely: Why don't these patients eat? Why are they so obstinate and full of negativism? and furthermore, what meaning could our words, actions and reactions at a given moment have for the patient? These questions of course lead us into a complex field and I cannot do justice to the psychopathological as well as the psychosomatic intricacies. The psychosomatic

aspects of anorexia nervosa go beyond the abstinence from food, but this certainly plays a major role. Perhaps the discussion will allow elaboration on the psychodynamic connexions of hypermotility and kleptomania, disgust, fear of poisoning, vomiting and hypochondria, constipation and abuse of laxatives, sexual fears and amenorrhea.

The classic descriptions are corroborated by experiences gained in psychotherapy but supplemented on the descriptive level as well as, of course, on the etiological and therapeutic level. The most important descriptive addition is perhaps that these patients do not suffer from anorexia strictly speaking. The topic of food with all its variations and derivatives is in the patients' thoughts. As with all starving people one finds illusory wish-fulfilments and the ascetic patients are prone to similar cravings and impulsive acts as people in dire hunger. Experiences in starvation, whether forced or voluntary, are quite similar. A comparison in this respect between the so-called Minnesota experiment in semi-starvation (Schiele & Brozek, 1948), war and concentration camp reports and an autobiographical novel by the Swiss girl. Berger (1944), who died as a result of anorexia nervosa, is very instructive. Many of the ascetic anorexia nervosa patients refuse the most delicious food but devour surreptitiously and greedily food remnants from the dustbin and develop peculiarly perverse tastes—for shoe polish, for instance. There are others who chew with very tiny bites for hours, and I had one patient who ruminated like a cow. Such excesses occur secretly. For a psychodynamic understanding it is essential to note that there is no real satisfaction, no pleasure without remorse or guilt feelings. Everything has to be reversed. The bites taken are spat out.

In order to understand this peculiar behaviour, this kind of undoing, I would like to make some remarks on the subjective aspects of hunger. As Lasègue pointed out, doctors knew little about it at that time. Perhaps it is appropriate first to say a few words about the biology of hunger. Margolin's (1953) sum-

mary of a paper by Janowitz & Grossmann (1949) is pertinent: 'The fact is that we do not have an adequate physiological definition of hunger, no secretory and motor activities of the stomach, no chemical changes in the blood, in short no bodily change has been consistently isolated or described which corresponds to the subjective sensation of hunger.' Phenomenologically and in the experience the biological act of taking in, of incorporation, is a prototype of object finding, contact and assimilation of an outside thing into oneself. In the subjective experience of hunger the ego depends on nature in a twofold way: the need to satisfy comes from inside and the drive is satisfied by an object which is early in life provided by another person, usually the mother. This dependency from inside on something outside brought all our patients into an unbearable conflict. Therefore the patients do not speak of any needs and bodily desires. The apprehension of the sexual development in puberty is concealed. The defence against drive representatives has the effect that sexual fears are displaced on to concerns about the physique although there is no obesity and on the average a normal weight. This displacement gives the figure a special meaning. Quite a trivial or teasing remark about the figure triggers off the whole process because the defensive manœuvres displaced sexual fears on to the whole body. In later stages ego distortions having the clinical severity of a delusion effect freedom from anxiety. At this point neurotic processes have led to a complete displacement of anxieties and patients are more apprehensive about food than about death.

Illusory substitute gratifications of various kinds permit quite remarkable compromises. These patients deceive themselves, believing they have finally satisfied their own needs by ruminating, by reading books on diet, etc. In this connexion I would like to mention the kind of altruistic care which these patients force upon their relatives or upon other patients. In short, they satisfy their own appetite by cooking for other people. Not too

rarely it is the mother who is forced to eat copiously and the mother's gain in weight parallels the daughter's loss of weight. This participation is brought about by identification processes which motivate the phantasy that the patient lives in autarchy. It depends on the identification processes whether the behaviour of the patient is more depressive, masochistic or hypomanic-narcissistic. The following observation is relevant here: one of our more severe cases was tickling her mother very intensively up to an hour or more daily. This tickling had libidinous and sado-masochistic qualities. At the beginning of the disease the tickling subsided. At the same time the patient stopped hitting herself and gave up imagining all kinds of suicidal attempts. Figuratively speaking, with the disease the struggle continued on the inner stage. Now the patient was full of depressive self-condemnation and at other times a hypomanic denial of an imminent danger of dying. I think that such a change can best be explained by assuming an identification with the internalized object representation. The self-condemnation then aims at the object representation with which the ego is identified. In their depressive state the patients, on account of the well-known introjection process, regard the dwindling away of their body as if it did not belong to them, and as if they were estranged from it. On the other hand, their euphoria can be understood by assuming that unconsciously these patients are united with their nursing mothers. Our observation leads to the conclusion that we must regard these unconscious fantasies as so effective that these patients believe themselves to be in a sense immortal. In short, their ego is characterized by a unique omnipotence. Although their narcissistic omnipotence has a pre-genital character corresponding to a certain object-loss and an unconscious union with their mothers, we observed other features as well. Some of these patients stick to the idea of parthenogenesis.

I would like to interpret under the same heading of 'autarchy' an observation already made by Lasègue and Gull, namely, about the

patients' hypermotility. Looked at from a certain angle, it belongs to the omnipotent illusion of being independent of external sources. They try to be a kind of perpetual mobile, always on the move. And they like to pretend that they are capable of long physical activity without needing a supply of energy. The reduced intake and the consumption through hyperactivity cause a loss of substance. There is no reason to believe in the miraculous enigma of this perpetual mobile. It can be explained by referring to the well-known fact that hunger stimulates movement not only in the imagination but also in the motor system. Hypermotility is part of the so-called 'appetitive behaviour' (Craig). Experimental investigations by Hess and his co-worker, B. R. Brügger, show clearly that electric stimulation of the hunger drive brings about hypermotility. In the absence of something edible the cat looks for a substitute object ' to discharge the tension caused by the stimulated instinct' (Hess, 1944/46). Anorexia nervosa patients are prone to 'displacement reactions' because the 'consummatory action' (Craig) cannot be realized on account of intra-psychic psychological reasons. If there is eventually a discharge, perhaps as a kleptomanic impulse, it is not accompanied by a real satisfaction of need. On the contrary, guilt feelings force the patient to some kind of purging viewed from this angle, their dancing, gymnastics and their excessive hiking serve as a cleansing act and at the same time the patients experience an ego-alien satisfaction in the pleasure of movement as Abraham has described it.

The observation that there is no real and full satisfaction seems to be important to the understanding of anorexia nervosa as well as in some cases of obesity. Either these patients experience only a bodily satisfaction by their greedy devouring which is undone by vomiting, or they live on an illusory satisfaction, on a kind of masturbation with food, as one of the participants in the Minnesota experiment in semi-starvation called it. It is not surprising to find anorexia and bulimia, loss of weight and obesity, alternating. One of our colleagues, Dr Mahler, had a patient who gained 10 lb. in 7 days (105–115 lb.). This 20-year-old girl weighed 92 lb. on admission and her height was 5 ft. 9 in. She interrupted the treatment weighing 157 lb. and developed an obesity which brought her back later. Two other followed-up cases were rather obese later. To my knowledge, the psychoanalyst Wulff first drew attention to the interesting relationship of this alternating oral symptom complex with addiction. Using the term widely, the addiction consists of the preoccupation with food as the almost exclusive object of thought. At the same time anorexia patients and some of their obese antipodes fight against this dependency. They are over-demanding and chronically morose: whatever you offer them it is not enough to satisfy their hunger. There is no object which encompasses all those qualities which food represents for these patients. Everything—tenderness, closeness, love, spoiling, care, etc.—are all looked for in one thing, food. And this has to be refused on account of its unconscious meaning. As a short illustration I will give the following part of a session:

The patient had written an essay on the topic 'Dialogue' at school the previous day. Now she was considering whether there is openness and mutual trust between human beings, comparable to the one between man and animal. It became clear that she looked for a pre-verbal understanding but was horrified at its intimate implications. The day before she had observed a school friend and her boy friend eating from the same piece of bread. The patient regarded this as a very intimate and disgusting intercourse. In her associations she centred upon receptivity and the chain of her thoughts was as follows: bottle—child—disgust if I think of it—injections—the idea that there is something flowing into me: into my mouth or into the vagina is maddening. Integer, integra, integrum occurs to me. Untouchable. Males cannot be touched as females. A man is untouched. He does not have to bear a child. A man is what he is. He need not receive and he need not give.

It is important to note that receptivity was given a female character and purity was ascribed to men in this case. As receptivity has a special connotation in female development this gives rise to sex-specific conflicts. No doubt it is fashionable in our times to slim. But the irrational extent to which it goes on is partly motivated by the antagonism towards passive-receptive feelings and functions.

The satisfaction of hunger, as we all know, leads to post-prandial fulness. These proprioceptive sensations link the function of eating with the Gestalt or, more correctly, the mental representative of functioning with the body image. (In Schilder's definition the body schema is the spatial image everybody has of himself, cf. Bruch (1962).)

Both representations, that is of the function and of the form and chiefly their unconscious roots, can lead to pathological conflicts. Thus human relationships on this level are complicated, because to eat from the same loaf of bread, i.e. *panis*, does not only mean to be a good companion. The unconscious sexualizing of the hunger drive is accompanied by body schema disturbance. It is remarkable that our only male patient did not fast mainly in order to reduce weight but in order to stop growth. He wished he was a girl and disliked getting bigger, becoming a boy.

A similar observation is reported by Falstein and his co-workers (1956) with four male anorexia patients. There are, of course, many more neurotic components in the picture. Asceticism, morosity and concealed demands are kept in balance. Through the secondary gain of illness these patients find substitute gratifications. Relatives, mainly the mother, and the hospital personnel, the nurses, are strained to a great extent because every care which would lead to a gain in weight is sabotaged at the last moment. There are many indirect ways of having substitute gratifications. One of our patients, for instance, used to upset her mother by her insatiable demand for warmth.

The essential psychodynamic features in anorexia nervosa are, in brief, as follows: the genital phase of development is abandoned objectively and subjectively. In many cases amenorrhea is the first symptom of the regression. Sexual wishes have disappeared from consciousness, an asexual ego-ideal has developed. Thoughts and behaviour are full of derivatives of, or reaction-formations against, oral impulses (cf. Jessner & Abse, 1960). The relationship between the patients and their mothers shows a typical ambivalence. Some of the patients start using again the utensils, spoons, etc., which they had as children. Theoretically and technically it is important to bear in mind the fact that, in spite of their behaviour, these patients are no longer stubborn small children—but grown-ups or girls in puberty who have regressed to earlier stages of libido and ego-development. Therefore oral needs are superceded by other layers and I would like to refer generally to their ego distortions. There is a certain similarity between their ego regression and the stage of hallucinatory wish-fulfilment. This gives the syndrome the clinical severity of a delusion. If the disease has developed to this point the somato-psychic consequences are not to be underestimated; neither in therapy nor in the reconstruction of psychogenesis. I would like to comment especially on the psychogenic reconstruction because the self-frustration, harmlessly as it may have begun, leads to a permanent stimulation of aggression in a vicious circle with guilt feelings, masochism, etc. Although agression also plays a role in the cause of the disease, the repressed aggression we find in these cases is coloured by the process of the illness. It would be rewarding to describe the differences of ego-distortion and the changes in object-relations in more detail than I am able to here.

It needs explanation to understand why the fight against drives makes the oral drive its prototype. I think it is essential to recall here the problem of dependency which is outstanding in the experience of hunger. The young patients especially believe, or should I say, act on the hypothesis, that they would be in a state of complete emotional surrender if

they fulfilled their hunger. Their negativism then is a means of liberating themselves from their mothers and objects in general. Unfortunately puberty asceticism and negativism can lead to the same severe inanition as starvation brought about by phobic, compulsive, depressive or paranoid psychopathology. The natural course of the disease seems to be more favourable in cases of puberty asceticism (as described by A. Freud), but the diagnostic differentiation is notoriously difficult in this age group and it is not easy to find out which case would have which natural course.

After this brief psychodynamic description I would like to make a few remarks on the treatment technique. The initial resistance of these patients is very strong. Anorexia nervosa patients are unco-operative to such an extent that it is justifiable to build a rough differential diagnostic evaluation on their behaviour, namely, an emaciated patient who seeks help rarely if ever suffers from anorexia nervosa. The main problem is, therefore, to overcome this initial resistance. We succeeded in getting only nineteen patients of the thirty sample cases into hospital. Nineteen cases *unwillingly* accepted treatment. I must admit, however, that almost all of us were beginners and these difficult patients were more often than not training cases. Slowly we understood these girls better and our growing understanding helped to make more therapeutically effective interpretations. It was our assumption that these patients can be reached through *interpretations*. At any rate, for methodological reasons we tried to follow psychoanalytic rules. As I mentioned before we were more successful in overcoming the initial resistance in the more recent twenty cases. Seventeen of this last group of twenty cases, referred to the hospital since January 1960, have accepted trial analysis after the first interviews. Needless to say the outcome still remains uncertain; but at least the first and essential battle is won and the most important therapeutic condition is fulfilled: the *patient* is *present*!

These small figures and differences do not allow a statistical evaluation. It was encouraging to see more patients agreeing to our therapeutic suggestions. Our doctors are now less emotionally involved and less prone to the described counter-transference, or rather, its acting out. Our assumption proved correct. It is possible to reach these patients by interpretative techniques and to bring about favourable changes in symptoms and personalities. We have satisfied our curiosity to a certain extent and we think that we understand these patients now better than we did some years ago. Although this has not in itself a therapeutic effect, it is a precondition for psychotherapy, because it changes the struggle for power in favour of the doctors. The struggle for power is transformed from the blind acting and counter-acting, from refusal of food and its forced intake into intra-psychic and interpersonal conflicts. In spite of failures, it is a great pleasure to observe the subtle, but powerful effect of interpretations and to enjoy a therapeutic process which leads not only to a substantial gain in weight. I think that it is this pleasure which makes it possible to bear the negativism of these patients. As long as there is a fight, a struggle for power on the level of symptoms, you will find actions and counter-actions, aggression and retaliation, lies and guilt-feelings, etc., etc.

Finally, I would like to recommend a few technical devices which have proved helpful. On medical as well as psychotherapeutic grounds it is advisable to hospitalize these patients. Only twice did we agree to an ambulatory brief psychotherapy from the beginning onwards. Unfortunately, the decision made by the patient and her relatives usually rests on one or two ambulatory interviews and much depends, therefore, on these initial encounters. In this early phase of treatment the dependency problem and the negativism can be used as starting points for interpretations. It is important to improve their mothers' co-operation by making them aware of their denial as a rather disastrous way of overcoming anxiety. The dishonesty of these patients with regard to appetite, food and weight is a very tricky problem. You cannot believe them. At what

point should one interpret their deceptions and self-deceptions without running too great a risk? The problem is that the patient does not mention all those very important secrets like vomiting, etc., of which she is perfectly aware. The earlier one points out that the idea of being a perpetual mobile is a self-deception, the better; otherwise the guilt-feelings about all the lies drive the patient further into her illness. Lasègue certainly was a very good clinician, but he was wrong when he thought that listening and observing is the only safe way. It would be too late to wait until the patient spontaneously talked about her problems, about secret orgies, cleansing, etc. Our ward is not a closed one and the supervision cannot be strict. Apart from emergency interventions we restrict the patient at critical times to bed. This is a very simple but effective way of making clear that in spite of all opposition the patient is a patient.

I would like to add a few remarks about the result of psychotherapeutic treatment. As already mentioned, nineteen of the thirty patients were treated by psychoanalytically orientated psychotherapy, the number of sessions being between 11 and 440. The average number of sessions was 113. Thirteen of the patients were in brief psychotherapy up to 72 sessions, six in psychoanalysis up to 440 sessions. Of the remaining eleven cases eight did not accept our therapeutic suggestions. One patient died 3 days after admission. One girl, unusually co-operative, improved after a few ambulatory interviews so markedly and lastingly that it was not justifiable to continue treatment which would have meant interrupting a crucial phase in her schooling. For external reasons we referred one patient to a hospital closer to where she lived.

The patients came into our hospital on an average of $2\frac{1}{2}$ years after the onset of the disease. All of them were unsuccessfully treated by a variety of means which I have described. When we made the follow-up study we looked, on average, at a period of $5\frac{1}{2}$ years since the onset and 3 years since examination or treatment in our hospital. Ten cases made a good recovery, four had still some slight symptoms and nine more serious ones; six cases showed no change over the years and remained chronically ill. The crucial question is: What are the therapeutic effects on the course of the illness? Eight of the nineteen treated cases improved or recovered with psychotherapy, whereas the improvement in nine cases was regarded as more or less spontaneous. That is, we did not know what brought about the change. Twice we noted a failure.

A comparison of the various groups is rewarding. What kind of difference is there in the course of illness and life history between those patients who received psychotherapy and the other groups, namely the ones who were not psychotherapeutically treated or broke off the therapy very early? We tried to be as self-critical as possible in answering this question. I feel justified in saying that psychoanalytic psychotherapy had a more favourable influence on these patients than all the other therapies which had been applied.

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Anorexia nervosa—progress of a case

By LINTON GRIMSHAW*

The writer has previously reported a case of anorexia nervosa showing features of aetiological importance (Grimshaw, 1959). The patient was a single girl of 17 whose weight had fallen to 6 stone, a loss of $2\frac{1}{2}$ stone. This was associated with loss of appetite and amenorrhoea in the absence of organic disease. She was treated with psychotherapy during the course of which she recalled, with the discharge of much aggression, an early childhood incident of fellatio. Clinical improvement appeared to follow. The illness seemed to have begun with the revival of this experience by current problems involving her father and sexual traumas of adolescence. It was suggested that the illness developed as a response to oedipal difficulties so that these traumas became charged with phantasies of oral impregnation by her father. Food, symbolizing the penis and semen was, therefore, totally rejected.

The patient, after treatment lasting a year, left hospital weighing 7 st. 2 lb. Her periods had not returned, however. Three months later she wrote to say she was well, her appetite was fair and her weight was maintained. Amenorrhoea was still present.

The present communication reports the progress of the patient 2 years after leaving hospital. It is an attempt to assess the effectiveness of treatment and to elaborate psychodynamic factors further. The importance of a follow-up study is obvious in a condition such as anorexia nervosa where relapse or partial recovery is common (Kay & Leigh, 1954).

PROGRESS

After leaving hospital, the patient went to live with an aunt in London. This person began

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to force food, particularly porridge, on the patient. This was done often in the presence of other members of her family and guests. When the patient refused, as she began to do, the aunt made apologies for her. Her weight fell again.

She returned home. Her appetite improved and she noticed a surge in energy and activity. She began working in Manchester but her anorexia recurred. She would try to eat her lunch and then become bad-tempered purposely to justify its rejection. She would find fault with the food, and nag her family to avoid eating, although she felt a duty to eat 'to butter my conscience' as she phrased it.

The patient began to control the household by her behaviour, at the same time effectively avoiding food. Her conduct involved her in difficulties with her mother. With her boundless energy, she tried to take over her mother's responsibilities—cooking, cleaning, serving at table, waking the younger children in the morning, and so on. She claimed to have the whip-hand, performing duties not hers but her mother's. This role was not enjoyed—'how could it be for that "shower"', she said, thus contemptuously referring to her family. She criticized herself, however, saying that she should have been the eldest daughter instead of a martinet. She felt that in some way she was making up for all the worry she had given to her mother. She concluded by saying that if she could eat a big meal sitting at table instead of waiting on others (like mother) she would have solved her problems.

Regarding her relations with boys at this time, the patient said that although she had had odd 'dates', she did not feel ready. She did not feel matured in body—'body like a child but mind grown up'. Since she did not eat normally, social activity in her view was prevented. As she put it: 'it's normal to eat,

therefore I'm abnormal to a man. I don't want what I can have—in both eating and love.'

The patient related the above at an interview, requested by the mother, a year after leaving hospital. Her weight had again fallen to under 7 stone and her periods were still absent. She failed to attend for further interviews until a year later. The changes at this time were striking. She was now an attractive young woman of good figure, weighing 8 st. 9 lb. Her periods, however, had not returned.

The patient reported that she was getting fat now—that she was 'mad hungry'. She was more lazy than previously and was not doing chores as formerly. She described her illness as something she had to go through—'a kill to cure'. She felt she would not have been balanced if she had not gone through it. 'That man [who assaulted her] must have depicted all men.' She now felt more assured with men and had experienced sexual desire. At home, 'father has had a stroke, affecting his writing hand, and has retired. Mother is well: she is more concerned with Dad now.'

A few months after this interview the patient wrote to say her periods had returned, that she was perfectly well, and thanked me for my services which were no longer necessary.

DISCUSSION

It seems clear that the patient's difficulties were not over after she left hospital. The patient had, in therapy, worked through much oedipal conflict with her father via the transference. It now remained for her to deal similarly with the jealously and hostility towards her mother, together with associated guilt. These feelings were shaped by pregenital, oral, strivings and hence appeared in conflicts concerned with food and the role of the mother as provider. There was an attempt to usurp the mother from her position in the family, described by the patient as a penance for worrying her mother yet enabling her to discharge her destructive wishes against her mother. The struggle involved similar reciprocal feelings on the part of the mother. She mentioned that if she could relinquish this need to displace her mother, that is, receive food from her mother instead of dispensing it like her mother, her troubles would be over. Recovery seemed to occur with resolution of this situation: the struggle with mother died away with the development of her father's illness and invalidism and the mother's preoccupation with his welfare. Gee's case is called to mind: 'she had been father's darling, but now that the family's sympathies were transferred from her to him she made a rapid recovery' (Gee, 1908).

Difficulties with the opposite sex had also recurred after leaving hospital. The defensive function of the eating difficulty was again noteworthy. She was thereby able to evade relations with boys, eating and love being equated in the patient's mind. Leanness was identified with the physical immaturity of the child.

Treatment of anorexia nervosa has been surveyed in a recent monograph (Bliss & Branch, 1959). A wide range of somatic and psychological methods have been applied with varying success. The case reported above appears to have been carried to a successful conclusion by psychotherapy. The treatment was not without risk. With the arousal of overpowering hidden conflicts, the patient's physical condition, already in jeopardy from inanition, was temporarily aggravated and threatened life itself. It would seem imperative that, before embarking on ambitious psychotherapy, the patient's nutritional state should be improved so far as possible by somatic treatment, if necessary at the hands of another physician.

SUMMARY

The progress of a case of anorexia nervosa is reported. Treatment by psychotherapy appears to have been successful. Complete recovery followed the final resolution of oedipal conflicts, particularly those involving the mother.

Acknowledgement

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An approach to the psychotherapy of cognitive dysfunction in schizophrenia

By JAMES CHAPMAN* and ANDREW McGHIE†

INTRODUCTION

The purpose of this paper is to outline a tentative approach to the psychotherapy of schizophrenia which has been derived from clinical and experimental studies of disorders of attention and perception. In the past few years, several workers have applied the methods of experimental psychology to the disorders of ego function in schizophrenia in attempts to assess the anomalies of thinking and perception occurring in this disease. For example, Payne and his fellow workers (1959, 1961) have investigated the 'over-inclusive' nature of schizophrenic thinking in an attempt at an experimental analysis of thought disorder. Weckowicz and others (1957, 1958, 1959) have carried out experimental assessments of perceptual deficiencies in schizophrenic subjects and have isolated such anomalies as disturbed size and distance constancy. Both of these groups of workers have interpreted their experimental findings to suggest that these disturbances in perception and thinking are secondary to a basic deficiency in selective attention.

In a previous clinical study of young schizophrenic patients, the present authors (McGhie & Chapman, 1961) arrived at a similar conclusion, namely, that one of the primary disorders occurring in schizophrenia is a breakdown in the selective-inhibitory functions of attention. In addition to this main hypothesis, the reports of the earliest changes in the experience of these young patients, obtained in standard

interviews, led the authors to formulate four secondary hypotheses which could be subjected to experimental examination. These were: (1) That schizophrenic patients are particularly susceptible to the distracting influence of auditory stimuli, which tend to disrupt both their visual perception and thinking. (2) That the difficulty in selective attention experienced by schizophrenic patients is most pronounced when they are required to inhibit stimuli in one sensory channel in order to deal effectively with information in an alternative channel. (3) That they have great difficulty in coping with situations demanding the integration of sensory data from more than one modality. (4) That sensory stimuli tend to disrupt the patient's motor performance and this is particularly marked with the occurrence of auditory stimuli.

These clinical observations and hypotheses were then subjected to experimental investigation (Chapman & McGhie, 1962) with some measure of success. It would appear that a rough map of the disorders of ego function in schizophrenia is now beginning to emerge although the outline is still very sketchy with many of its points of reference requiring further checking. This experimental psychological approach is still in its infancy, but the present authors would like to suggest that, even at this early stage, the findings might be utilized as a guide in the therapeutic approach to schizophrenic patients. The acceptance of an organic pathological process underlying schizophrenia need not force us to conclude that any form of psychotherapy is futile. The patient's psychological reactions to the alteration he experiences in relation to his environment form perhaps a secondary, but certainly an important, part in the development of the

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total clinical picture. It is suggested here that the schizophrenic patient's chief sources of difficulty are not wholly derived from unconscious conflicts, but are even more intimately linked to his increasing conscious awareness of the breakdown in his cognitive functions, which progressively alienates him from his environment.

Before attempting to outline this approach, it may be convenient first to review briefly some of the clinical changes exhibited by the patients, and then proceed to discuss the possible implications of the experimental findings for the treatment of schizophrenic patients, with particular emphasis on how these findings might be applied to establishing better communication with the patients.

CHANGES IN VISUAL PERCEPTION

Both the subjective reports of the patients and their test performances (Chapman & McGhie, 1962) indicate a failure in the normally automatic capacity to perceive the environment in terms of meaningful gestalts. The schizophrenic patient appears to require to carry out the perceptual process in a conscious and deliberate fashion. An added difficulty occurs in that during perception of one source of visual stimulation, stimuli arising in the auditory sphere or from another visual source bring about a breakup at some stage in the patient's initial perceptual activity. By way of clinical illustration of this phenomenon, a young male hebephrenic reported at the onset of his illness—'Everything I see is split up. It's like a photograph that's torn in bits and put together again. If somebody moves or speaks everything I see disappears quickly and I have to put it together again.'

It may be worth emphasizing that the dimension of time has an important bearing on the schizophrenic's perceptual performance. Because he has consciously to direct his attention in order to integrate sensory information, the patient experiences a temporal lag before the perception of this information is effective, and it is during this time that his perceptual activity is vulnerable to the disrupting effects of additional stimuli from other sources. This appears to apply to the perception of memory images as well as the external environment. For example, another patient stated—'I have to build up a picture of someone. If something interrupts me, the picture is not finished. You did it just now. You spoke while I was building up the picture. I was trying to hold on to it and listen to you at the same time. I lost it. You spoke and it faded away'.

Related to their difficulty in integrating information simultaneously from multiple sensory channels, the patients show a distinct tendency to register more quickly and more effectively concrete changes in their environment. Ordinary verbal communication is frequently ineffective unless it is limited and presented at a slow rate of change. The observer's actions, gestures, mannerisms, facial expression, appearance and dress, tone and pitch of voice all tend to take precedence over the content of his speech. This affinity for concrete perceptions showed by the patients, not only affects communication adversely, but may give rise to other symptoms, due, for example, to false interpretation of the observer's movements as independent meaningful signals.

It was noticeable in this study that the patient's symptoms tended to vary according to the content of their current perceptions. In this respect the range of symptomatology was very wide, but perhaps the most interesting example of this kind was reported by several of the sixty patients studied, who stated that when they focused their attention on a memory image of the opposite sex, then, for the duration of that perception, they subjectively experienced a bodily change of sex. This sensation abated with a change of attention to another source of stimulation. This rather curious phenomenon tends to suggest that certain psychological symptoms of this kind, with their associated affective components, need not necessarily be derived from dynamically repressed conflict but may be determined directly by the breakdown in attention and perception.

CHANGES IN THE PERCEPTION OF SPEECH

Since any form of psychotherapy involves communication, it would seem of paramount importance that the therapist has a full appreciation of the schizophrenic patient's difficulties in the perception of speech. It is in this cognitive area that the present authors find that one of the most profound disturbances arises as a result of impaired selective attention. In his attempts to screen out disrupting stimuli, the patient can exert some control over what he is looking at but usually he has little or no control over his auditory intake. As a result of the primary breakdown, the schizophrenic has to attend consciously, with deliberation, to each unit of information as it is presented. If the information given to him is concrete enough, he will more readily perceive its meaning in time and give a more spontaneous and appropriate response. Because of the temporal delay involved in this method of perception, verbal information as he hears it initially may have no meaning for him. One catatonic patient said—'You can hear the word but what actually the word means takes its time in coming in. You have got to find out the meaning of the sentence. I have to search carefully'. Several patients reported that when feeling compelled to respond in such conditions they simply 'guess the answers'. In order to invest any verbal item with meaning, the patient has to break away from the other person's speech and redirect his attention internally to select from memory the appropriate symbol which he then consciously links with the verbal stimulus. Thus at times even single words can become for the patient a source of considerable difficulty and his perception of unbroken speech requires a rapid series of changes of attention between the observer's speech and his own internal store of information. Some patients referred to this in terms of a double conversation taking place, the patient feeling in a kind of no-man's territory between the external observer and his own mental processes. A student patient stated—'I feel as if I am always talking to another bit of myself. Sometimes it thinks itself wiser than I and cuts me off from myself'. Another young male schizophrenic of good intelligence reported—'Somebody might say something to me. They might say the word "bare". I would have to go over three or four words to get the meaning of what "bare" is. It's like scrambling, the way they used to do in the war. Things are broken up and then they have to be put together again into something I can understand'.

Thus any continuous conversation may be a source of stress for the schizophrenic with the emergence of anxiety and other emotional symptoms. The patient frequently fails in attention and at these times heard speech becomes for him just a babble of noise. It is in such circumstances that the non-verbal aspects of communication assume great importance. When the patient does fail in listening attentively he often demonstrates echolalic responses which provide a useful indication to the observer that he is proceeding too quickly in communication. The patient's attention may stray away from the observer's speech and be taken up with more primitive stimuli of a visual nature. In our terms of reference, the patient simply gives up attempting to perceive in two channels, and reverts to receiving communications in a single sensory channel. Another patient said —'When you lose track of people's conversation it has got to be visual. I have got to see somebody to carry on a conversation. I need to listen longer. It doesn't make sense what they say. You read it in their faces what they are saying'. The last comment from the patient illustrates how non-verbal communication comes into play when the patient experiences difficulty or failure in the perception of speech.

Lastly, if in such difficult conditions any further stimulation occurs, the patient's attention may become even more diffusely directed, with overloading of his perceptual mechanisms, which may culminate in total blocking of all forms of communication.

CHANGES IN MOTOR OUTPUT

Another consequence of the primary breakdown in attention appears to be an impairment in the automatic control of motility so that the patient's movements have to be carried out in a conscious, deliberate manner. The patient has to anticipate the different stages in any complex movement and then consciously co-ordinate them into a smooth sequence. His motor performance tends to be slower than normal and may be broken up by extraneous, especially auditory, stimuli. A characteristic statement from these patients is as follows: 'If I do something, like going for a drink of water, I have to go over each detail. Find cup, walk over, turn tap, fill cup, turn tap off, drink it. I keep building up a picture. I have to change the picture each time. I have to make the old picture move. I can't concentrate. I can't hold things. Something else comes in. Various things. It's easier if I stay still.'

Likewise, there appears to be a failure in the automatic abstraction of stored information for the purposes of motor speech. The patient requires often to search deliberately, select and check the information he wishes to convey. When he fails in this, he tends to revert to a more primitive form of expression, using gesture. Thus a patient reported—'I try to do without words. I think what impressions I want to give and then try to show them with movements. I might gesture with my hand or move my head—facial expression—display displeasure by frowning. I don't let the words revolve in my head—just the meaning. I let the meaning run round in my head and understand it'.

This change in the communication process, whereby movements are substituted for words, may be related to secondary delusional symptoms concerning telepathic control. Another patient said—'I like talking to a person but not in audible words. I try to force my thoughts into someone. I concentrate on how they move. I think of a message and concentrate in my head. It's thought you're passing over. I send the messages by visual indication.

Sometimes it's my foot, but it might be my arms, legs, sometimes the shoulder, sometimes my whole body. I had the impression other people started this. They made movements first. I could contact back. They had a certain control over my body'.

IMPLICATIONS

These changes in cognitive function described above are being subjected to further experimental investigation with a wider scope. However, the test findings so far obtained allow us to draw some limited conclusions and say something of their possible implications for the treatment of schizophrenic patients.

I. *General environmental conditions*

It would seem likely that schizophrenic patients will experience improved cognitive function in conditions where there is a limited or reduced environmental stimulation. There have been some attempts recently to apply sensory deprivation techniques to schizophrenic patients by various workers, with somewhat conflicting results (Harris, 1959; Smith, Thakurdas & Lawes, 1961). The present authors' findings do not point to the likelihood of a beneficial effect being obtained by indiscriminate reduction of all forms of stimulation. While one might interpret these findings to suggest that the schizophrenic does suffer from an overloading of his perceptual system, the best therapeutic results appear likely to be achieved when the patient is allowed to have a specific intake maintained through one sensory channel, preferably visual.

It seems probable that the actual environmental conditions prevailing at a particular time will have a bearing on the patient's symptomatology and behaviour. For example, the patients are likely to be worse in respect of some symptoms in large, noisy wards where there is much irregular activity and where their visual and auditory senses are bombarded simultaneously by multiple stimuli. In these circumstances symptoms such as hallucinations, withdrawal or catatonic behaviour seem

more likely to emerge. Two noteworthy sources of two-channel stimulation are provided by television and film shows. Numerous patients in this study reported that although, the outside observer might notice them sitting quietly at television, they were in fact assimilating very little of either the visual or auditory components. Some of the youngest schizophrenic patients told us that they could follow television programmes better on either vision or sound only. It would appear that, in many cases, cognitive dysfunction is worsened by stimulation from such sources as television and it may not be illogical for patients frequently to refer much of their persecutory symptoms to such sources. Auditory hallucinations and confusion are more likely to develop if the patient's perceptual system is taxed beyond its capacity. On the other hand, if the patient's attention can be engaged in a single sensory channel, such anomalies will tend to diminish.

It would seem important also to apply this reduction in perceptual contact to the patient's social environment. Possibly the most complicated source of perceptual stimulation, with a detrimental effect on the cognitive performance of the schizophrenic, is a group of other people who bombard the patient with talk. The majority of the patients in this study appeared to have some awareness of the effect on their cognitive function of other people's communication with them. This in turn seemed to be linked with a wide variety of secondary psychological reactions. For example, a patient stated at the onset of his psychosis— 'It all boils down to the fact that people I was talking to, started talking nonsense like babies. I thought I had driven them mad. Their talk was all jumbled up. I can will them to talk nonsense. I can control people through the ether and make them gibbering idiots, who talk a lot of rubbish'. Frequently these perceptual and other cognitive anomalies were interpreted by the patients in a more paranoid fashion and, if the authors' view of schizophrenic experience is correct, then paranoid reports of a hostile environment which seeks to control him may perhaps be a readily understandable conclusion derived from the patient's own subjective experience of reality. The schizophrenic is likely to do better if his immediate personal contacts are initially kept to a minimum, say a team composed of one doctor, one nurse and one parent.

Finally, it is probable that occupations which involve multiple channel stimulation and irregularity in perceptual intake will have a deleterious effect on the schizophrenic's performance. The patient will do better in tasks where he is required to engage in limited motor activity, where he need mainly use his eyes and where the task involves few sequential changes, with sufficient time given for him to adapt to these changes. This would have a bearing on the structuring of occupational therapy and work rehabilitation schemes for schizophrenic patients.

II. *Individual treatment situation*

A main aim in the individual treatment of schizophrenia is to establish better communication with the patient. It has been implied that an understanding of the patient's perceptual difficulties will facilitate this and a relationship will more readily develop. It seems likely too that the maintenance of a relationship with the patient is at least partly dependent on initially establishing successful communication with him, and not the converse. For example, overloading of the patient's perceptual system, which might develop even with attempts at normal communication, is likely to induce negative reactions and withdrawal. The psychological approach outlined in this paper involves the 'uncovering' of phenomena which may not be superficially manifest. However, what is 'uncovered' may have no connexion with unconscious conflicts but may have to do with the patient's subjective experiences and problems in the field of attention and perception, and any explanations given to the patients are on this basis. In other words, the patient is gradually allowed to ventilate and come to understand his cognitive disabilities, and then

encouraged to deal with these disabilities in such a way that he can achieve and maintain a greater degree of perceptual constancy in relation to his environment.

It may be worthwhile elaborating some practical aspects of this approach. First of all, the arrangement and contents of the interviewing room are kept constant, since the patients are perceptually so sensitive to concrete changes, even to the dress and appearance of the therapist. The interview is conducted with the patient and the therapist sitting squarely face to face, the patient being in a position where he can easily see everything around him, and where he can see the therapist's face and expression clearly. This facilitates the purely physiognomic aspects of communication. All extraneous sources of stimulation in and outwith the room should be reduced as much as possible. Even the hum of the tape recorder used in this study was a frequent source of disturbance reported by patients. The therapist should remain relatively immobile and restrict his actions or gestures unless these are used to transmit meaning. The interview need not become too mechanical or rigid, but it is important to avoid 'irrelevant' movements while attempting to communicate verbally with the patient. The patient should not be left to initiate communication but his automatic verbal responses should be encouraged by providing him with suitable verbal stimuli. Verbal communication itself should be limited, using well-defined items or ideas, and illustrated more by gesture. Verbal information may be more effectively transmitted if it is delivered at a slow, steady rate with scanning of phrases. Abstract words or ideas should be avoided. Where the communication does become more abstract, which is probably inevitable, then the patient must be allowed sufficient time to refer to his own memories and respond without the therapist interjecting new verbal or other stimuli into the patient's perceptual system, with resulting shattering of his mental activity. As mentioned earlier, echolalic responses from the patient sometimes indicate to the therapist that he should slow down or allow the patient a short rest.

In this treatment situation, what the therapist is attempting to do is to engage in verbal interactivity while both he and the patient keep all other activities relatively constant. In other words, he is attempting to communicate with the patient as much as possible in a SINGLE, SENSORY CHANNEL, while taking sufficient time to do so.

The essential requirement in verbal communication is to take the content of what one intends to convey and alter it in such a way that it more readily accommodates to the patient's altered mode of perception. This involves presenting him with small, easily retained, isolated units of meaning which are structured so that they stand out in sharp contrast to the general perceptual background. In this way, the content of transmitted meaning becomes more 'real' or 'convincing' for the patient.

The patient is encouraged to convey his meaning in his own way, and this may involve considerable use of gesture. He should not be discouraged or distracted from engaging in visual fixation while he is speaking, since this happens naturally to reduce his visual perceptual intake, which might otherwise interfere with his performance. A number of patients reported that they often found it helpful to engage deliberately in visual fixation. For example, one patient stated—'When the confusion comes on I just look at something and keep my eyes on it. I usually fix my eyes on the nearest thing in front of them and stare and stare until I'm not seeing anything at all'. Irrelevant verbal stimuli should be avoided whenever the patient is engaged in any kind of motor activity.

In short, the therapist is virtually attempting to operate at the same level as the schizophrenic patient feels compelled to do. By such measures communication seems to improve and patients often report to the effect that—'They feel on the same wavelength' as the therapist.

This concept of a primary disorder of at-

tention and perception in schizophrenia implies a physio-pathological disturbance of some kind in the brain which exerts one of its main effects on these particular cognitive functions. This does not necessarily mean that the resulting impairment in mental function is intractable in the sense that it cannot be modified by appropriate methods of treatment. There does not seem to be any convincing reason why schizophrenia should differ from other serious diseases of the nervous system in that the individual patient may retain a considerable reserve capacity for the recovery of impaired nervous function. It is possible that in schizophrenia, as in other cases of cerebral disease, although there may be some, at any rate temporarily, irreversible disturbance within the brain, there may remain healthy areas which, when brought into active operation in suitable conditions, can take over, in some measure, functions with which these areas were not previously associated.

It seems logical to find out and assess what the patient's actual defects are and then proceed to deal with them in a systematic way. In this approach, therefore, the treatment is focused on the patient's specific cognitive disabilities in perception, speech and motility and so on and attempts to deal with these in a way that will improve the patient's general performance. Although the patients have difficulty in the perception of speech, which detracts from successful verbal communication, nevertheless, when attention is paid to the form of presentation, and to the total stimulation received by the patient, this difficulty may to some extent be overcome so that less dependence need be placed on non-verbal aspects of communication.

As in other diseases, the earlier treatment is commenced, the better seem to be the results. It has emerged fairly clearly from this study that some of the earliest affective changes in schizophrenia are causally linked with the breakdown in cognitive function. When these specific cognitive difficulties begin to be ventilated by the patient and understood to some extent by him, such secondary re-actions appear to diminish in quantity and intensity.

Other secondary reactions which can be observed in schizophrenic patients viewed against this background of specific cognitive dysfunction appear to have a common underlying aim, which is to reduce quantitatively the intake of sensory stimulation at any particular time. Such methods of self-help, which the patient may naturally adopt, vary in their effectiveness and impact on the patient's behaviour and adjustment to his environment. When the schizophrenic has advanced to the stage where he thus limits his sensory intake by plugging his ears, keeping his eyes closed, facing the wall in a catatonic position, or persistently refusing to be diverted from preoccupation with his own fantasies, then it is probably rather late to expect much as a result of treatment on the lines suggested here. But such faulty reactions could perhaps be corrected if detected early enough. For example, the patient who found that going for a drink of water required his undivided attention and stated—'It's easier if I stay still', might, if left to his own devices, have developed more catatonic-like behaviour. In this instance the patient was reassured that he could move without having to refer consciously to a series of concrete images of movement. By giving him simple instructions—'to let his body move on its own and nothing disastrous would happen', he was encouraged to carry out actions without devoting his whole attention to them. With sufficient practice in this, his motor performance improved. Another patient who found it exhausting to keep checking his own speech said—'I can't control the actual thoughts I want. I can't compare it with my speech. I think something but I say it different. People listening might hear something different from what I mean. Sometimes I do not say anything because of this. I keep the words in me'. This patient might possibly have developed mutism as a secondary feature had this tendency not been corrected from the outset. In this case it was explained to the patient that 'keeping the words in him' was a

bad method of dealing with the problem. Instead, he was encouraged to practice talking freely to the therapist without fear of being misunderstood and without conscious searching, selecting and checking. He was instructed to 'let himself talk and the words would come themselves'.

The patient is gradually weaned away from ineffective reactions associated with his cognitive disabilities. More and more, with regular practice, he is encouraged to achieve a greater degree of perceptual constancy in relation to his environment by attempting to engage in perception in a single sensory channel, while trying deliberately to ignore stimuli in other channels. He is likewise encouraged to refrain from attending actively to his own movements, from monitoring his own thinking and speech, or from trying to attend to multiple stimuli simultaneously. In short, he is encouraged to regain some conscious control over selection and inhibition of stimulation, and thus achieve a better control over his efforts to adapt to his environment.

The experimental investigations into disordered attention and perception in schizophrenia on which this approach is based were derived from clinical observation of patients receiving psychotherapeutic treatment along psychodynamic lines. The provisional approach outlined in this paper represents a very crude attempt to transfer the experimental findings back to a clinical setting. Such an approach will require much further investigation, particularly with regard to its efficacy in the prevention of some secondary developments in schizophrenia. It may be that, as further experimental research reveals more detailed information on the nature of the cognitive breakdown in schizophrenia, we shall be better equipped to devise a more systematic and possibly more specific method of psychotherapy.

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The perception of the body surface

By ROBIN HIGGINS

INTRODUCTION

In this paper an attempt has been made to build up a picture of the 'body surface' as perceived by relatively healthy people in the course of ordinary conversations, group discussions and more formal interviews.

The conversations have usually been centred on one or more cosmetic products. They represent the raw data of work done by the Tavistock Institute over the years in this and related fields.

The techniques of obtaining the data are based on free association by the individual or group under observation with minimal intervention on the part of the investigator. It was felt that only by these means could one begin to get at the less conscious implications of more conscious utterances, and that until one began to tune into these implications, there would be serious gaps in any understanding of the presenting situation.

THE BODY SURFACE AS A BOUNDARY

Though subject to repeated messages from their body surface people for the most part remain largely unaware of these and make little attempt to relate them and their mediating source such as the skin into any very organized picture. In this they are treating the skin in its 'normal' state as they would any other 'normal' organ, namely by taking it for granted. With the skin, however, as part of the body surface and the central role it must play in delineating the person this apparent unawareness in healthy adults is somewhat surprising, especially as underlying the apparent lack of structural definitions people do hold more primitive conceptual models of their skin and the way it contains them.

In the adult there is little persisting awareness of moving about in a skin or of moving about behind a clear-cut boundary line with the outside world. When people describe their body surface they tend to concentrate first and foremost on textual characteristics and on the feelings in the skin such as liveliness or deadness, moisture, greasiness, etc. Such characteristics are determined more by associated structures in the epidermis (blood vessels, sweat and sebaceous glands) than by the dermis and epidermis themselves.

Thus the skin may be described as 'sensitive'; it will respond quickly and intensively to sunlight or bracing preparations. It will feel 'burnt up' and 'raw'. Again there is a universal tendency, perhaps enhanced by advertizing copy, to rank one's skin on a dry greasy scale, and despite accepted variations in different parts of the body and at different phases of one's life to type oneself as a dry-skinned or a greasy-skinned person.

For some women their greatest preoccupation is with the appearance of cracks and wrinkles in the skin surface or white hairs on the head. A beauty culturist noted that her regular customers were among the over forties who would come in once a week for facial treatments, in an attempt to resist changes in the body surface which they saw as tantamount to a death of a part of themselves.

The nearest most adults come to more detailed structural conceptions of their skin would seem to be when they speak of 'the pores'. The way the activities of the skin are perceived and the functional concepts tend to accord with this.

For most people, again encouraged by advertizing copy, the 'pores' largely make up 'their skin', the model they have in their minds of the skin surface is of serried ranks of pores, opening and shutting, swollen or flattened out like so many sea anemones. The pores are 'swollen', 'distended', 'clogged'; the pores can or cannot 'breathe'. The pores are seen

as tiny sacks with a narrow opening. They are thus in a sense a miniature of the 'primal cavity', that is to say of a primitive image for body surface and orifices.

In primitive thinking there are at least two ways in which the body surface may be delineated. In the first it will be seen as a boundary between a solid block and empty air. A young woman who took great pains with her natural and beautiful complexion described how she would no more dream of using a certain astringent preparation on her skin than she would of polishing her furniture with Ajax. With this and other remarks she seemed to be seeing her body surface as akin to the surface of solid furniture; a surface separating a solid block from the air circulating around it; one rendered immobile by the solidity behind it, but a surface primarily for display in contrast to the hard functionalism that it was covering.

The other mode of delineating the body surface replaces the solidity by a hollow core, or at least with some sort of gap between it and its contents. In this model the skin is seen as containing the body and the self within it, as providing a framework for them, a house within which they can be disposed and ordered. Whereas in the previous model the body was seen as a block, with skin and other features of the surface a somewhat indefinite peripheral layer, in the second model the skin is seen more as an integrator. It is the skin rather than the body block which is felt to be holding one together, something without which one would become depersonalized, or simply fall apart. Thus the psychological significance of a wound, a breaking of the skin, lies in this sense of destroying the container, bursting the bag and letting the person contained flood out and drain away.

In both conceptual models, but especially in the second one, the surface is endowed with a thickness and a thinness and, perhaps more important, with degrees of permeability. These three characteristics are concerned with the maintenance or dissolution of the boundary.

The thin skin, a membranous layer, is naturally seen as easily penetrated. A thin-skinned person is felt to be a sensitive, vulnerable creature. He is seen as someone who has barely framed himself out from his environment or from other people around him. If pricked, he shrinks into himself—or in more extreme instances, destroys impressions of himself as a person and merges with his surrounds.

A thick-skinned person may be seen as the opposite to this, someone who has a clear conception of what he can or cannot do, of where he is going and where he has come from. More usually, however, he is also assumed to have an insensitivity as exaggerated as the thin-skinned man's sensitivity. In its extreme forms it may progress to the state described by Peto (1959) where, in regressive transference fantasies, the skin or the flesh was felt to swell inordinately, until it filled and engulfed the analyst and his room. In these cases the sense of boundary between the self and the not-self was dissolved not by the bursting of a thin membrane but by the hypertrophy of the body surface to such a degree that it 'engulfed the world'.

Besides the breaking of the body surface by occasional transient lesions, such as wounds or boils, the surface is also seen as being recurrently penetrated by the growth of hair. The regular morning upthrust of hair through the facial skin of men is associated generally with virility but also with the extrusion of noxious internal products and with the break down of that body surface barrier which keeps these back from the world. The same would seem to be true for hairs in the armpits or on the legs of women. One of the reasons for shaving would seem to be the removal of these phantasied noxious products, their transformation (with the aid, for example, of after-shave lotion) into an acceptable form and the restoration of smooth surface continuity.

In certain body areas, however, on the scalp particularly for women and on the chest for men, hair, at any rate in the present day and age, is not only a permissible but a commendable penetrator. It would seem as if there were

certain surface areas which are reserved for easing the outcrop of 'what goes on inside' or of lowering the threshold on the interchange of inner and outer. Just as on the surface of the sacred cathedral there is a place reserved for monstrous gargoyle faces up to monstrous gargoyle practices, so on the body surfaces there would seem to be a need to reserve similar places to sanctify the ugly.[*]

This recurrent penetration of body surface by hairs modifies the idea of the skin as a rigid person/extra-person boundary. But in any case even in those areas where there are no hairs, the surface tends to be seen as permeable in both directions. Two-way traffic occurs across the boundary. On the one hand creams and other preparations are seen as entering into the skin and passing through it into the body. Skin creams are as 'nutritive' as other 'creams' would be that are taken by mouth. In the other direction sweat, grease and other waste products are seen as passing out of the skin 'through the pores'. Astringent preparations are seen as discouraging their formation or encouraging their departure, 'drying the skin', sucking out these internal secretions which reside in and behind it. Besides perspiring the skin is also felt to respire; besides protecting it also 'digests'.

In other words, in keeping with a basic psychosomatic principle, many physiological functions more usually associated with other organs tend to be attributed to the skin. The skin is seen as an area of nutrition or of excretion. Products which are brought to bear on it are often viewed in terms of these other organs: they feed the skin or they purge it.

Women naturally tend to keep distinct skin preparations seen as carrying out different functions, or seen as penetrating the skin to different degrees while carrying out these

functions. A skin cleanser, for example a surface purge, will be seen as functioning mainly or only on the surface. Its purpose is getting dirt off the surface, scouring the surface, and it will only be felt to be safe as a scourer so long as it stays on the surface.[*] Cleansers must have some grease in them or else they would not be able to combine with the surface grease and thus remove it, but in determining the amount and the nature of the grease one has to tread warily. A miscalculation could easily land the preparation in the nutritive area and thus destroy its purpose. Purges are not only non-nutritive. They assume many of the features of what they are purging. Because they 'get out' the dirt they are themselves seen as dirty and hence in some ways 'poisonous'.

Conversely, skin tonics are preparations which are seen as 'making the skin alive', changing its colour into rosiness and generally lighting up a dull complexion. A woman described them as 'fresh air to the skin'. They penetrate the skin and 'fire' it. They must be applied gently and only after the skin surface has been cleaned by other preparations. No one would want the penetration and the fire sullied by a lot of grease and dirt.

This surface penetration and permeability combines with 'thickness' or 'thinness' images to create a constant ebb and flow in the clarity of boundary definitions. Put differently, the psychological boundary of the skin is constantly breaking down under the impact of certain states of mind. Perhaps these are best subsumed under Balint's term 'a new beginning' (Balint, 1952). They range from the moments of refreshment, wiping the face with a cleansing pad, to the more regular and ritual

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[*] In our discussions we have met the phantasy that different people's sweat, which tends to carry, of course, less pleasant associations, comes out in different places. One woman thought her sweat came out through the hairs of her head; others, she felt, less fortunate than she, had to sweat through their armpits.

[*] On the other hand, the idea of the surface activity of scourers has to be linked with the idea behind any cleaning process that it is not only surface but 'inner dirt' that is being tackled. One of the reasons why doubts are so often expressed about the efficacy of cleaning agents lies in the conflict between the wish to keep the agent on the surface and the belief that it is inner cleansing (i.e. cleansing of the dirty aspects of the personality) that really matters.

processes of cleaning and shaving to the full experience of being in love. These states of mind contribute to the symbolic significance of the face. They include many sensations experienced in falling asleep, those moments when interest is withdrawn from the outside world and devoted to the self* and the inner world, and to 'feeding' both with dreams.

The activities this wide range of 'new beginning' experiences has in common include removal of shrivelled, dirty skin or skin products, a drawing out of these and a shedding of them; a break for a greater or lesser length of time in the 'boundary' which is felt to separate one from someone else or from the world around him, or his 'outer' from his 'inner' self; and a reconstruction of boundaries on a new basis often with the 'inclusion of more' within them.

THE BODY SURFACE AS A PLANE OF CONTACT

So far, for the sake of exposition, we have spoken of the surface boundary in relative isolation and as though it only existed between the body-self and what lies beyond it. As soon as the complementary concept to 'a boundary' is introduced, however, namely the idea of the surface as a 'plane of contact', various over-simplifications inherent in this treatment will become apparent in at least two ways.

For if the skin is seen as part of a communicating system, a mediating layer as it were between inner personal and outer extra-personal worlds, then its relation to both of these may become highly complex. It is not just that the body surface system is connected with other systems, such as the menstrual cycle, and

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* The care and reparative work which women carry out on their skins tends to be separated by them from other cosmetic and make-up work, the one occurring at night, the other by day. Many realistic factors in their working lives determine this separation, but it does also seem to express a certain psychological split. Skin care becomes part of the general, recreative night process: in thus caring for the skin one makes good the tiredness of the day and makes it possible to appear again the next day as a 'public self'.

with expressed aspects of these other systems in the form of physiological concomitants or symbolic representations, it is that something of a boundary 'filter' becomes set up between the two. The surface system as it were becomes split off in the total organism. It becomes possible to distinguish between what reaches the surface and is expressed there and what does not.

It is common folk-knowledge, for example, that cyclical changes and skin conditions are associated with menstruation, but the variety of such associations, the direct or converse relations between the two systems, provide a striking illustration of the degree of autonomy which exists for each. Thus one woman who denigrated her skin and felt she was not born with a good one and had always had trouble with it, said the only period when she really felt her skin was 'lovely' was the week before her menstruation. In the period of pre-menstrual tension her skin felt cleansed and healthy and clear. With the onset of menstruation this healthy feeling in the skin disappeared. It seemed from this description that a sense of well-being in her surface system was inversely related to such a sense in her psycho-sexual one.

The whole purpose of cosmetics plays straight into this distinction between the surface system and the rest of the organization of the personality. This distinction does not, of course, necessarily imply that the surface system is necessarily at odds with the rest of the personality; it is not necessarily a 'false self' system in Laing's sense of the term (Laing, 1960). But it does imply the potentiality for this to occur. The nature of the articulation between surface system and total personality depends on the degree of a sense of embodiment, on how much one can accept the body as part of one's true self, or alternatively on how much one finds it necessary to deny one's present body as such and to define the 'true' self in psychic terms or in a 'better' body achieved with the aid of cosmetics.

A not infrequent determinant of women's preferences in cosmetics is whether they are seen as bringing out the natural self or whether

they are seen as masking this. To some extent this varies with different products applied to the skin. In a soap or other cleansing preparations a neutral scent is usually sought. One asks of it no more than that it will allow the 'natural' body odours to come through. For many women, what is asked of cosmetics and perfumes is for them to leave her feeling and smelling 'natural' or at any rate for their scent to blend in with what she sees as her natural (personal) good smell, their colours to blend in with what she sees as her natural colour.

This woman represents a degree of 'embodiment' which would put her at one end of a range.* At the other end of the scale would be the woman who 'so hates the sight of her face' that she can never bear to leave it unmasked. For example, one woman interviewed, an actress, would use up to twenty or thirty different lipsticks and take about an hour every morning just to make up her face. The perpetual reconstructions of her features was not confined to her face; changes in her hairstyle and eyebrows would accompany changes of make-up with the same startling rapidity. Sometimes she would shave off half the eyebrow and pencil in a line in a different direction or she would shave off the whole of her eyebrows and pencil them in a different sort of fashion. She was perpetually experimenting with new brands of make-up, and her bathroom cupboard sounded as if it was full of discarded illusions that had gone sour.

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* It is arguable that, since she put on make-up at all she has not really accepted her natural self, and that there is room at this end of the range for an even more 'embodied' person, namely one who ignores all forms of artificial skin care. Despite the trend towards increasing 'naturalness' in our present culture, such an out-and-out nature woman would still be somewhat suspect. Her behaviour might well arise not so much from an acceptance of her 'natural self' as from a lack of healthy interest in it, as though she did not consider her face good enough to care for or as though by her flouting all conventions she might deliver a rebuff to society or a denial of her own femininity.

For such a woman there is often an excess of anxiety about keeping make-up on, and excessive preoccupation with methods of ensuring permanency. She was dependent under this 'artificial self' for a continuing sense of integration, and chinks in the armour, revelations of the 'natural self', aroused excessive concern.

Another range, parallel to that drawn between those whose surface system is articulated in line with the total personality (the 'embodied') and those whose surface system is articulated at right angles, as it were, to the rest of the personality, could be drawn up for the uses to which this surface system comes to be put. For clearly the mask may be used to enhance a prevailing personal mood or alternatively to enhance a prevailing social convention which may at times conflict with or override the personal mood. Like an actor's mask, the cosmetics may be used to heighten whatever it is that the whole person wishes to express or to divide this expression into different and sometimes contradictory channels.

The particular woman instanced above as being at the end of a range where she found her natural face least acceptable also in fact claimed that she put on the many different shades of lipstick with the express purpose of bringing up the different moods she was heir to. Her frequent change of make-up not only arose from a restless dissatisfaction with her 'natural self', it was also in keeping with her way of coping with this dissatisfaction. Whereas another woman who felt depressed might seek to overcome this by putting on a cheerful mask, the actress, one inferred, would be more inclined to accept the depression as a transient mood and make up in tune with it.* A third

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* This actress also enjoyed the process of being made up, especially by a man. 'You lie back as if you are at the hairdresser, and he makes your face up, and it is lovely.' It was as though she displaced much of her genitality, her sense of being, into her surface system, particularly the facial part of it, and that this part then had to be fed 'or perpetually rejuvenated' by the application of cosmetics in order that it could continue to express herself.

type of woman might be so depressed or depressed in such a way that no amount of a mask would be felt adequate to influence her in the same way as no amount of deodorant may be thought to influence one's own bad smell.

Besides, then, the relations of the skin to the 'worlds' which exist on either side of it, the second major complication introduced by the concept of the surface as a plane of contact is that the surface itself does not function as a unified system. This is implicit in everything we have said to date about make-up. For clearly by long-held conventions some areas are more prone to be made up than others, and these, of course, are areas which are thought of as playing a greater part in the initiation and maintenance of contact. The face is perhaps most frequently, consistently and compulsorily exposed to the environment; hands share in this to a marked degree. Over the rest of the body there is a wide range in the practice and permissibility of exposure.

Within these exposed areas there will be certain unwritten laws relating different parts. For example on the face a certain inverse relation exists between eye make-up and lip make-up. It is generally accepted that, if the eyes are made up very heavily, very little lipstick is put on and vice versa.* The effect of the upper half of the face is balanced against that of hair, clothes, nails, etc.

Those parts of the body surface most exposed to direct 'social' contact tend to undergo a different 'psychic' development. They contribute a different set of elements to the total body-self imagery and receive somewhat different treatment. A further distinction, however, in the way different parts of the body surface are perceived lies in the geographical distribution for the body of the parts themselves.

Except in the mirror one can never see the

* This may have to do with whether one is seeking to present a 'sick' look with hollow eyes, deadpan whiteness, ashblond hair, etc., or a 'well' look with rouge, lips and ruddy cheeks. The sick or well look may be dictated by social fashions. Clearly little is to be gained by confusing the effect by introducing elements of the one into the other.

surface of much of the face, still less the surface at the nape of the neck or the back. These parts, in other words, and what comes up against them have to be learned about in a way a blind man learns in terms of touch, temperature and pressure. That is to say one tends to get to know them mainly, if not only, by sensations from the skin and the underlying tissues.

The world conjured up by sensations from the skin and the front part of the body is coloured by the addition of the stream of sensations coming through the eye. For much of the back scalp and to a lesser extent the face this is not so. Here one moves in a world where the sensations are predominantly those of touch, pressure, contracting muscles and so on. These differences in type of sensation stemming from different areas will be recorded in the developing imagery of the body surface as a whole.

THE INFLUENCE OF LIFE-CYCLE CHANGES ON THE PERCEPTION OF THE BODY SURFACE AS A BOUNDARY AND PLANE OF CONTACT

Most of our discussions to date have been with adult women and our observations on developing perception of body surface have been based on retrospection rather than on contemporary childhood comments.

Within this adult group, however, certain developing phases can still be distinguished. The exact forms of cosmetic behaviour, the purposes different cosmetics are seen to serve and the nature and extent of phantasies around the body surface which they activate vary considerably in the different phases.

The first phase lasts from adolescence to marriage. For the woman it is characterized by considerable uncertainty about her changing physique and about her changing (often rapidly changing) role in society. It is a period in which the girl will be most concerned in clarifying the relations between her surface system and her total personality and between herself and society. She will be engaged in coming to terms with what she does or does not wish to express publicly and with the way in which

she intends to express it. This is a period of repeated exploration, trying out and building of new kinds of relationships with people and new activities. The basic uncertainty, coupled with the pressure of development, makes for a repeated experimentation with new roles at a 'skin deep' level or in the surface system. In cosmetics new brands and combinations of brands are sifted incessantly.

At this period too conflicts about sexual development are often at their height. Sexual feelings have not yet won real acceptance and are often coloured by excessive guilt (genital and pregenital). There is thus an urge to repudiate any idea of entertaining such feelings. This the more so since at the period too there is a low threshold between the rise of internal feelings and indications of this rise in the body surface in the form of blushing or acne.*

For this reason among many adolescent girls there is an urge not only to try out different types of make-up but to put on thickly those which are tried. The actress instanced above said she used to put on a 'tremendous amount of make-up' when she was fifteen. She used to think it was absolutely essential to 'plaster herself' with it. Now that she was older (by some four years) she was more conservative and more discriminating.

Once married, and more particularly with the advent of young children, a woman is likely to experience considerable reshaping in her perceptions of her body surface and its relations to her total self. Feeling more secure in her acceptance of herself as a whole person (as well as others' acceptance of her) she will find it less necessary to exert careful selection of what aspects of herself she is prepared to expose publicly. In the close and continuous intimacy of marriage and under the scrutiny of her children's eyes it will become increasingly difficult to maintain an effective persona at 'right angles' to her true self.

In marriage too she has less need for erotic

* The point about acne is not so much whether there is or is not some relation between it and sexual functions but that it is commonly believed that there is some such connexion.

gratification from the physical care of her own face and body. Her growing heterosexual relations detract in part from her previous investment in homosexual and narcissistic ones.

With the onset of middle age the patterns of body surface perception resume in a milder form something of their adolescent guise. As the children grow up and leave her the woman is once more thrown back on herself. She has to seek her gratification more within herself. In some ways identifying and in some ways in rivalry with her daughters (being often bullied by them as they try to make her into a good sexual model) her interests and concern in her surface persona will be revived.

Moreover, with the increasing demands nowadays for her services in various jobs, she will find herself moving from a home atmosphere, where 'public persona' matters little, to one where it may matter greatly. Experiencing again something of the same uncertainties of role as she did in her adolescence (especially with the onset of the menopause, with its temporary increase in sexual desire, its anxiety about the reduction in desirability of the sexual object, etc.) she will tend to lose the security of her own being and may well need to boost this up by renewed interest and experimentation in clothes and make-up, by assuming a 'rejuvenated' skin, and by reassuring herself and others that she still cares about what she looks like and about what she permits them to see of herself.

THE RELEVANCE OF THESE FINDINGS FOR PSYCHOSOMATIC RESEARCH

In psychosomatic research the main stream of information to date derives from states associated with disease, e.g. peptic ulcer, ulcerative colitis, etc. This is not surprising since such research will have the backing of a socially acceptable and eminently practical purpose, namely the alleviation of suffering. Disease states, too, often provide a dramatic illustration of mind–body interrelations. More important perhaps, this illustration is one in which both parties to the 'experiment', ob-

served and observer alike, are most likely to be wholeheartedly involved. When people are ill or in need of help (as journalists have long appreciated) they are most prepared to divulge personal intimacies or submit to physical examinations which otherwise they might regard as personal indignities.

The disease setting in which psychosomatic studies are carried out does, however, have certain inherent disadvantages. In the first place it tends to set up and maintain a somewhat circumscribed view of illness (particularly as regards its social significance) and a distinction between illness and health that in its black and whiteness is somewhat unreal. In the second place if, as has been suggested by some writers (e.g. Wisdom, 1959), a primary concern of psychosomatic research at present is an investigation of 'imagery', of what people feel about their body or parts of their body and its functions and the way in which they experience these feelings (e.g. in visual or kinaesthetic terms), then it is surely arguable that initial studies should be carried out in states of relative health rather than relative illness. For it would seem unlikely that one would ever get a clear base-line, a clear picture of the disposition of forces and trends in imagery from studies arising out of states where such trends by definition are distorted and 'abnormal'.

In the third place diseases seem to have a natural tendency to carve themselves off into 'entities'. In part this may be a reflexion of the effect a patient and his illness has upon the doctor. For most people in most illnesses a particular diseased part and the particular way in which it is diseased tends to preoccupy them wholly in its more acute stages anyhow. One has only to think of the total absorption of all energies and interests demanded by a severe toothache. As a result psychosomatic studies based on disease states contain at the back of them a conceptual model of categorization that chops the body into as many bits and pieces as can go wrong. The instances quoted at the start of this paper, peptic ulcer or ulcerative colitis, are examples of the excessive

segmentation which models based only on diseased states are likely to impose. In this respect it is perhaps worth noting that studies not primarily 'disease orientated' [e.g. Benedek and Rubenstein's work on the sexual functions of women (Benedek & Rubenstein, 1942)], have often grown around a physiological function involving a group of body parts rather than around a particular body part, and a particular instance of this part's potential pathology.

In other words, studies based primarily on disease states are apt to overlook the context in which the disease occurs, the physiological function on which the pathology is based, and hence to overlook the interrelation of body parts as a dynamic process.

In our explorations, partly from what people say about their skin indirectly, partly from what they say about the effects of different products sought for and applied on their skin, a picture is emerging of the way 'relatively healthy' individuals perceive their skin, the conceptual model or 'body image' they retain of it and modify, the part skin perceptions and this model play in their total psychic and social life, the interplay between the images the possession of a skin evokes and the images evoked by surrounding events which come to be 'pinned' on the skin.

It should be stressed that the subjects did not present (at any rate overtly) because they had some skin complaint. They represented a cross-section of the population at large and not of the 'skin diseased' segment of it. We were thus able:

(1) To obtain some idea of the relation of health to disease by being perpetually reminded of that important category: 'the abnormal in the normal'. The recurrent pathological though transient skin changes, such as acne, 'pimples', scratches, chilblains, or boils, are part of the life of most 'normal' people. We were able to see these changes and the part they played in psychic life against the background of this 'normality'. Whilst certainly not getting a detailed picture of an abnormal state and its psychic accompani-

ments, we could begin to move towards a picture of the more usual personal gestalt where a transiently defective organ, a transient break in a part, is 'pulled back' by the organism as a whole and does not instead reshape the gestalt.

(2) To clarify the context of the body surface: For in the data it became increasingly clear that a separation of the skin and the images aroused by sensations from the skin or what might be termed the *skin* world in any clear-cut way was arbitrary and at times misleading. People think of their skin as part of their body surface on a par, that is, with certain ectodermal outgrowths: hair, eyebrows, eyelids, nails, skin appendages, and to some extent special sense organs such as eyes. It is not fortuitous that these are catered for in a group by the cosmetic firms. People see these parts *en bloc*. In make-up skin is matched to hair and nails; the parts are interrelated and if one is brought up the other is played down. The change in one part will influence markedly feelings about the whole. For example, a woman described how a visit to the hairdresser's was the one action which would relieve temporarily her conviction that her skin was wrinkled, yellow and dead.

THE RELEVANCE OF THESE FINDINGS FOR THE TREATMENT OF SKIN DISEASES

Though most of these findings have stemmed from investigations centred on some commercial product, a skin cream, an astringent lotion or a soap, they may well have a bearing on the choice of any pharmaceutical preparation. For over and above any specific therapeutic characteristic contained in, for example, a skin cream there are those many other characteristics of a more universal nature, such as the cream's colour, consistency, smell, any one of which by the associations it arouses may enhance or mar the desired therapeutic result.

For example, from the work described there is a strong suggestion that there may be marked differences in perceiving what the skin 'needs'

and hence the form of preparation best fitted to serve these 'needs'. The need may be voiced for a preparation to move into or 'draw things out of' the skin; assuming a prescription can be put up in a variety of different forms, such as a powder, a cream or a liquid, then the choice of that particular form must surely be influenced by the particular 'need' which the patient has procured and specified. Alignment of the preparation's form to the patient's need in this way might well increase the over-all effect of the treatment or at least prevent some of its effects from being vitiated by extraneous factors. The skin of the woman who could not abide the idea of any deep penetration of it by an emollient cream or a skin tonic is *a priori* unlikely to respond favourably if she associated any therapeutic preparation offered with one or other of these cosmetic varieties, regardless of what they contained. The effects produced by the form alone regardless of content might determine the outcome of her treatment.

In considering some of the factors involved in this choice of pharmaceutical the following diagram summarizes some of the ways in which perceptions about the body surface may play into the process of 'cure':

Perception based
on general
personality patterns

Imagery playing a
part in the formation
or resolution of

Imagery associated with
medicament and its
foreseen or actual effect

Type of body
surface lesion

Type of reaction
at body surface

Type of
medicament
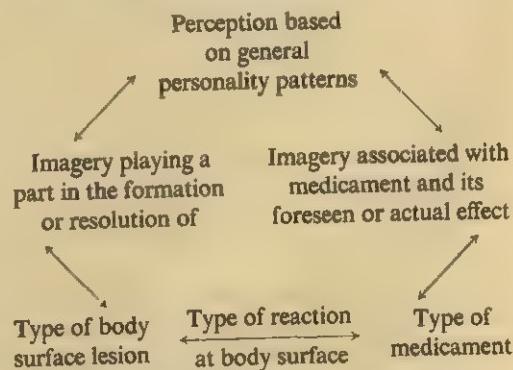
Diagram to illustrate perceptual channels between central imagery and peripheral medication.

It will be seen, in other words, that, as in any psychosomatic illness, there is a constant give and take through symbolic imagery between general personality dispositions, sentiments, attitudes and type of peripheral skin lesion.

In the same way it is suggested that there may be a similar give and take via imagery aroused by therapeutic agents, between general personality disposition and the response of the skin lesion to any particular agent. In considering the effectiveness of any therapeutic agent, it would seem important not to overlook the influence of these different 'stages' in imagery.

SUMMARY

In an attempt to arrive at a clearer picture of the way people perceive their body surface and the conceptual models they build up around this we have relied on data emerging from individual interviews and group discussion centred on a range of toilet preparations. The advantages of such an approach over, for example, the disease-centred setting of more usual psychosomatic studies are discussed.

The two main concepts covered in this paper are that of the body surface as a boundary and that of the body surface as a plane of contact. The two concepts are clearly complementary and are distinguished mainly for the purpose of exposition.

The variations these concepts undergo at different phases in an adult woman's life-cycle are traced and some illustrations are offered of the bearing the concepts themselves and their changes have on psychosomatic research and on pharmaceutical preparations applied to the body surface.

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Puerperal depression and excessive compliance with the mother

By GWEN DOUGLAS

Working with a research grant from the South-West Metropolitan Regional Hospital Board the writer interviewed a large number of women with emotional disturbances around the time of childbirth and studied a small number in detail. The patients were seen at University College Hospital and also at the Cassel Hospital where mothers with a psychiatric illness are admitted with their children (Main, 1958). This clinical experience supported Hemphill's finding that there is a clear-cut clinical entity of puerperal depression, distinct from manic-depressive psychosis (Hemphill, 1952), and the work of other writers (Brew & Seidenberg, 1950; Boyd, 1942) who suggest that the patients have a characteristic type of personality. This paper is largely concerned with this type of personality, and aspects of it which lead to the breakdown, particularly that which grows out of the early relationship between the patient and her mother.

CHARACTERISTICS TYPICAL OF THE PATIENTS STUDIED WHO DEVELOPED A PUERPERAL DEPRESSION

They came from families where the parents had stayed together and were concerned for their children when they were young, although there had sometimes been separations in the family when the patient was past the toddler stage.

They had worked somewhere near their capacity at school. They had enjoyed some games and group activities, and had been able to make a few friends.

They had worked to provide themselves with a livelihood on finishing their education.

They had achieved marriage with a man they respected and cared for.

They wished for children and had feminine interests.

They were capable of sustained affectionate relationships.

They were likeable and were co-operative at the ante-natal clinic.

It will be noticed that the group did not include psychopathic personalities, patients suffering from psychosis, nor the major psychosomatic disorders, obsessional neurosis or hysteria. Some had suffered from minor neurotic symptoms, but none had undergone previous psychiatric treatment. This is consistent with Hemphill's finding that only one out of forty-four patients with puerperal depression had a previous psychiatric illness.

A series of these patients were treated and the typical findings are perhaps best illustrated by the detailed description of one.

Mrs A.

Mrs A.'s father, an accountant, was meticulous, quiet and retiring at home. He had several children by a previous marriage. Her mother was felt by the patient to be an intelligent woman with a powerful charming personality who had over-protected the patient and had not allowed her daughter to do much for herself. She had always wanted her daughter to be a credit to her, so had chosen for her friends whom she thought would be suitable, and discouraged her from seeing those of whom she did not approve. The patient had tried to assert her independence when she had grown up, but her mother had continued to treat her like a child. She selected the patient's clothes and tried to organize her life until, and to some extent ever after, her marriage.

The family had moved about England, partly on account of the father's occupation

but also because the mother enjoyed moving, and the patient went to many schools. In spite of the changes she enjoyed school, won medals for swimming and diving, made friends, and passed her school certificate. She left school at seventeen, trained as a secretary, and held several positions in this capacity, but she always looked forward to being a wife and mother rather than pursuing a business career.

She was fond of her husband who came from a united family, and she was happy after her marriage. Her husband had a University degree, and enjoyed an interesting position with good prospects. They lived in a flat and planned to have a house of their own later. It fitted in with their hopes and way of life when the patient became pregnant. She was well during pregnancy until near the end when she became despondent over her mother organizing, with neat efficiency, for the expected baby.

The labour was reported by the gynaecologist as having been normal; the patient had the usual discomfort towards the end of the first stage.

After the birth of the baby Mrs A. was delighted, but on returning home on the tenth day she became depressed. She had to test weigh the baby and give supplementary feeds; this and the baby's crying upset her. She was frightened of caring for the child, and panicked when alone, wondering what she should do next, so the General Practitioner arranged for a nurse to come in the mornings to bath and feed the baby, and he prescribed sedatives at night for the patient. After a few weeks she seemed rather less depressed, but she lost confidence soon after and was again unable to manage, so her General Practitioner sent her to a psychiatrist. He prescribed Largactil and arranged to see her once a fortnight. Mrs A. complained to him that after the birth of her child she did not want to talk to her mother, and that she was still disturbed after her mother's visits, so the psychiatrist suggested that the mother should not see her daughter for a time, but should give her an opportunity to manage on her own, and develop her independence. However the patient became more lifeless and depressed, with self-reproaches saying that she was the worst person to care for her child, and at later interviews she reported being lonely and 'shut-in' when her mother did not come.

It now seemed to Mrs A. that she was unique in her inability to love and in her hatred towards her child. She wanted to destroy the child and made an attempt to do so, but kept this secret, being ashamed. She watched herself as if from outside, lacked spontaneity and was constantly judging her thoughts and feelings which were unreal to her. It occurred to her that even her husband, whom she had loved tenderly and with whom she had shared such hopes, could no longer understand her. His happy childhood and united family, his ability to enjoy the company of others, which she had previously valued, now acted as a barrier between them, as she thought that a man with these advantages could never understand her utter wretchedness. Her illness appeared to her to have gone on for a very long time and she was sure that she would not recover. She contemplated suicide as her only solution.

This picture of puerperal depression with depersonalization was classic for our series.

When the baby was five months old the psychiatrist, concerned by the patient's withdrawn state, referred her to the Cassel Hospital. Here the patient and her husband were interviewed by the writer, and the mother by another therapist. The suicide risk was clear and made us consider the question of the patient's admission to hospital carefully. Mrs A. would surely have had understanding from the nurses and assistance from the other patients in hospital but her husband's support was, we felt, more important for her. The husband was clearly worried about his wife: he showed understanding and maturity and a capacity to co-operate with the hospital staff. He could be trusted to get in touch with us at once if the patient required more help, and his sensitivity towards her needs would enable him to be aware of this very early. We decided therefore to treat her as an out-patient.

She was offered psychotherapeutic interviews of fifty minutes twice a week. It was explained to both husband and wife that psychotherapy being hard work, the patient would probably be able to do less in other ways, during the period of treatment. The husband asked about the likely duration of the illness. This question was not answered directly, but it was emphasized that the patient should be allowed to get over her illness in her own time. The husband took leave for three weeks and when this expired, both for economic reasons and for the sake of his morale, he was advised to go back to work. It also seemed important then, to minimize the guilt that the patient had, over disturbing his working life. Mr A. co-operated throughout treatment, supporting his wife through periods of anxiety, encouraging her to continue the treatment and giving practical help, thus making it possible for her to attend. His attitude, which we encouraged, was an important factor in the favourable outcome of her treatment. (In other cases, where the husband's personal resources were less reliable, the woman was admitted to hospital.)

An account of some of the material from the psychotherapeutic interviews follows. It gives some indication of the patient's relations with her own mother, on whom she was unduly dependent, and whose ideas she had previously adopted particularly easily and how these were no longer satisfactory to her after the birth of the baby, and yet how difficult it was for her to reach any solution on her own. Interpretations were offered in a tentative manner, and a constant watch was kept to avoid the patient developing a similar dependence on the therapist.

Early sessions

At first the patient found it difficult to talk. She said she cried a lot at home and could not manage the baby. In a flat unemotional way and so quietly that her speech was scarcely audible, she asked what she should do and if someone else should look after the child.

I let her know that I thought she was giving me to understand that while she was offering me the responsibility of deciding what should happen to her and the baby, she was miserable at doing this rather than being able to cope herself.

A few sessions later, when she came alone, she said that on her way to the hospital she was panicky that she would lose her way, or that the car would break down. She asked if I had heard from her previous psychiatrist. I suggested that she wished to hear from her previous psychiatrist herself, that she was disappointed she was not going to see him today, so perhaps this contributed to the feeling that she was going the wrong way, because it was the wrong psychiatrist she was going to see. The patient said that her previous psychiatrist had understood the background so well. She was still strained, spoke quietly and with long pauses. She believed herself to be incompetent generally, and unable to look after the baby. She was getting panic attacks and when the baby cried she felt unable to cope and feared she would lose her temper with him and harm him. She said that her mother had told her how irritable she was as a child, but she herself remembered bottling everything up. She went on to say that her previous psychiatrist had suggested that she might see less of her mother, but she did not think that was the answer, as she needed her mother's twice weekly visits. I commented that she seemed so attached to her mother that perhaps what she wanted was a change in her relationship with her mother rather than a break. Mrs A. said that she did worry about her mother all the time, and this she could not understand. She was continuously afraid of her mother's disapproval. I suggested that she was now having the same difficulty with me, that she was trying to say what I expected rather than whatever came into her head, however odd, trivial or seemingly irrelevant these thoughts may seem. She relaxed and spoke more spontaneously, but was still diffident.

She spoke about her half sister who brought up her children with no discipline and how she did not want to do that. She had theories

about bringing up children, but worried lest she could not put them into practice. She could not see what would happen to the baby, whether her mother would take him altogether, or if she should have him adopted as she could not imagine herself bringing him up. She *never* felt a good mother and hated herself because she was so horrible now, selfish, stupid, and ignorant. I asked if she felt guilty at thinking of herself at all, instead of the baby, and related this to her need to think of her mother's wishes before her own as a small girl. Mrs A. said with emotion that it was not only as a small girl but even now she felt like that about her mother, and she just could not get away from it. I suggested that it was difficult for her to claim any competence as she considered her mother to be the capable one without equal, who must not be rivalled. Mrs A. said that as her mother was so efficient she had spoilt her with this tendency to manage her affairs. It was more difficult for her than her half sister as their mother cared so much more for her than the other. I commented that perhaps the patient also cared more for her mother and her good opinion.

At another interview Mrs A. reported that she found herself doing things for her baby in the same way as her mother, and this made her despairing since she was dissatisfied with her own upbringing. She added that she had not previously realized the importance of childhood in development of character. She found it easy to think of what she was going to say to me before she came but difficult once she arrived. She told me how awful she felt if left alone with her baby, as she had a terrible fear that she would kill him. She remembered one day when the baby got into a rage, and she became panic stricken but fortunately her husband coped with the situation by doing what was necessary for the baby. Mrs A. became tense and found it difficult to go on talking. She mentioned a discussion with her previous psychiatrist about going into hospital—she had thought of this as being 'sent away'. I asked if perhaps she was reluctant to tell me the really disturbing things lest I would not be able to bear it and send her away. She agreed and said that she felt at times she wanted to do away with herself. I asked if perhaps this was a wish to avoid harming the baby rather than to stop living. She repeated that when left alone with the baby she felt utterly incompetent and that everything had changed since the birth of her child. She was so happy before, she liked her flat, her belongings and her friends, now she hated them all. I asked her if this implied that she saw her husband differently. She said her husband did not understand her and could not do so since he had a happy childhood and had always been secure.

When we had finished the interview, she told me that her mother had suggested that she should have occupational therapy. It seemed that the patient had asked her mother to teach her how to knit and her mother had replied that surely they could do that at the hospital. I made the comment that perhaps her mother suggested we do this rather than giving her own help when asked, because she was finding it a little difficult to bear that someone other than herself should be caring for her daughter. I suggested that we try to understand the implications of what was going on as well as support her to make any arrangements that might be suitable.

At another interview Mrs A. told me that she had decided the treatment was likely to be useful to her. She had despaired of finding help, thinking that no one had the same feelings as she had. She said now that she really wanted to tell me everything. She had a confession to make to me; at a previous session when I had gone out of the room she had looked into the books on my desk and had seen a description of her own feelings. This had made her really believe that she was not alone, that I might be able to understand. I said that besides having gained knowledge for herself she felt she had defied me and instead of the disaster she always expected should she defy her mother, good had come of it. She said she really did not know where to begin, about her feelings for the baby or herself as a child. I suggested

she might say whatever came into her head and we might try to understand it as we went along. She was ashamed of what she had to tell me and she was so afraid that I would be shocked. I said that perhaps her fear of shocking me was lest I cease to treat her, as she was unable to tell her anxieties to her mother when she was a child lest she lose her mother's concern and approval. She said that she did wish I would tell her it was alright, that it was not wicked as much as a form of insanity. I suggested that she was asking me to help her understand what was going on in herself rather than condemn her, just as the important thing about looking in my book was that she herself got to know that other people suffer from these illnesses, which was more effective than my having told her. The worry on her mind was that when she returned home from the obstetric hospital she had hoped that the baby would die. The baby had a cold but she did not call the doctor as she wished that it would develop into pneumonia and that the baby would die; in addition, she considered dropping him on the stone steps and had actually tried to smother him. Then she had felt so wicked that she decided to kill herself. By this time she was inclined to have thoughts about harming the baby only when she was particularly tense. When the baby put his face against her clothes and made them dirty she felt enraged. I asked if she found the mess intolerable, but she said no it was more a matter of the baby getting the upper hand of her. She reported how she had been depressed towards the end of pregnancy. She had been very happy when she got married, as she had felt she was now Mrs A. and she would be able to make her own decision. Then towards the end of pregnancy she suffered these depressions, especially when her mother rang up, to tell her all the things she was planning for the baby, the patient felt that she herself would be a hopeless mother. At this time she felt that she must try to get away from her mother. She was infuriated that her previous psychiatrist had apparently got on so well with her mother, she believed that they found one another

charming. I inquired if it was because she thought that her mother had captured the previous psychiatrist's interest, so that she could not even have her therapist to herself.

Later sessions

The patient's mistrust of the psychotherapist, on to whom she transferred the feelings that she had towards her mother, gradually became apparent. All the hatred at being frustrated by someone she depended on and loved was relived in the transference. The sessions were often tense with the patient's fury and hate. Gradually, as the anger was expressed, through the transference interpretations she came to recognize how she and her mother had related to each other, and how inappropriate many of the restrictions imposed on her throughout all stages of her development had been, and the part that she had played in accepting these restrictions rather than defy her mother and show her own anger. It was considered important that she did not give up compliance with her mother's wishes only to replace it for compliance with those of the therapist, which could have been the outcome. She learnt to trust her feelings and to be able to form independent judgement, and to tell the therapist quite clearly when she disagreed. She no longer felt her mother's word was law, and worried less about her approval, recognizing that her dependence on her mother belonged to the past. She could stand by her own decisions quite firmly and yet was still fond of her mother and now enjoyed her visits. As her confidence in her feelings increased she could stand being hated by her screaming infant, and tend the child without getting upset.

She had six months' regular psychotherapeutic sessions twice a week and then attended twice more during the next month. By this time she knew what hard work was involved in running a home and caring for a child, but she had come to find it satisfying. She not only enjoyed her baby but had regained her old respect and affection for her husband. She took more interest in people outside the home and

seemed to be quietly helpful to her neighbours.

Before Mrs A.'s baby was born, she was a pleasant accommodating person who would agree with others and easily adopt their viewpoint, and she could work conscientiously. She was, however, not inclined to express her own ideas, she lacked spontaneity, being carefully controlled and inclined to live her life within narrow limits. Her clothes like her speech and general manner were conventional. After treatment she was more flexible and able to state her opinions in an attractively spontaneous way. She surprised herself by choosing clothes in a greater variety of styles and colours and by mixing freely with people, with whom she would previously have been shy and stiff. She discovered enjoyment in nonsense of the 'Goon' sort. Mrs A. had changed from a well-behaved conventional girl to a broad-minded but discriminating young woman, capable of making independent decisions. Thus it seemed that treatment had not only relieved her depression but effected a change in her personality.

The patient later had a second baby with none of the old difficulties, and she has remained well, living a full life with her husband, and their children.

Discussion of the sessions and psychopathology

The outstanding content of these interviews was the relationship with the mother, in two important aspects: (1) an unusually deep affection for the mother, together with a wish to please her and conform to her wishes, (2) an enormous criticism of her mother never expressed, for not allowing the patient to reach her own true feelings sufficiently to make independent judgements, or to try out activities while she was at a stage where she might fail or make a mess. That these two feelings existed side by side had to be steadily interpreted; if one side only was stressed, the patient felt misunderstood. While this technical problem occurs about conflicts in any patient, it was particularly tempting to see in this patient only the patient's dependence on

the helpful mother or her previously silent resentment towards the mother. Moreover, the patient was unable to correct the therapist's errors of emphasis, for the mother's anxiety had driven her to mould her daughter to a pattern which gave the patient insufficient confidence in her own feelings and judgement. Such a relationship with the mother has been described by Sylvia Markham (1961) whose findings were based on psychological tests in patients suffering from puerperal psychosis.

DISCUSSION

I suggest that the illness I have described is a distortion of the normal state following childbirth. A new baby absorbs the mother and demands almost her entire attention (Winnicott, 1956). To achieve the state of 'primary maternal preoccupation' the mother has to give up past relationships in their old form, and lay them aside for a time. The process of change is of course begun during pregnancy which in itself represents the important maturation crisis (Bibring, 1962). This involves a review of the relationships and a sadness at relinquishing them, a miniature mourning. It includes, too, neglecting her other interests with perhaps some regret (see the discussion by Deutsch (1947) on the conflict of ego interests and instinctive maternal interests in puerperal depression). During the last weeks of pregnancy and after childbirth a woman is therefore introspective and vulnerable; she needs a relative freedom from other worries to make the proper emotional adjustments, to concentrate on the needs of her child when he is born, and yet remain integrated, to use judgement and a sensitive empathy in deciding what is necessary for the child in the way of food, warmth, quiet or company, even when the baby's mood is one of rage.

Our patient took the usual course of giving up external interests with little difficulty, but she became preoccupied with the review of relationship with her mother and could get no further with this, for she could not give up her

old way of complying with her mother's wishes, and so become an independent person capable of thinking and feeling for herself, and her baby. When she felt attacked (e.g. by her baby's anger) Mrs A. was not able to assess the situation as a whole, but could only think that the other person must be right, and she would wait until told what to do. The patient thus related to her mother and subsequently to other people chiefly on a basis of compliance. (The dynamics of this type of relationship is described by Winnicott in *Psychosis and Child Care*, 1952). She did what she was told and what another person wanted, suppressing her own wishes and feelings to an unusual degree. This was consistent with her type of behaviour at school and in life generally; she was friendly and accommodating, but unclear about her own wishes and unable to get to know other people well enough to fulfil their needs, unless they asked or indicated what they needed. She had never been in a position of caring for a dependent until she had her baby, when for the first time she could not relate in her usual way. She was as subdued by his crying as she had been by her mother's disapproval. With a person not dependent on her she would have waited until told what to do, or she would have done nothing, but the baby could not say what he wanted, yet he was her child whom she had expected to care for, who seemed to her to be screaming at her in protest and making her feel hopelessly inadequate. In this tense situation she would panic, as the repressed anger against always doing another's bidding broke through and she would then attack the child, only to become overwhelmed with remorse afterwards.

Mrs A. has been described as if her condition was relatively uncomplicated, and as if she had had no other conflicts, etc., but (as in most patients) these were evident enough. However, the underlying conflict with the mother, hidden under compliance, was prominently noted, and not until this was resolved did she recover.

It is widely recognized that illness does not always occur with the first child and even women who have had several children successfully, may break down with the child who they feel will be their last. It is interesting to observe that the clinical picture may again be one of depression with depersonalization similar to that shown by Mrs A., but this subject is sufficiently complicated to require a separate paper for adequate explanation.

Type of treatment

The type of patient suffering from puerperal depression which Mrs A. illustrates seems most suitable to be referred to a psychotherapist because following childbirth previously unconscious thoughts and feelings become accessible. It is true that this may lead to the development of an intense and dependent relationship on the therapist which can cause difficulties in the treatment if insufficiently understood. If these transference phenomena are familiar to the therapist however, they can be used to help the patient, not only with her symptoms of depression, but also to alter her personality structure and way of relating to others.

Physical treatment may make the patient less depressed, but often leaves her depersonalized, and although she may be enabled to care for her child physically, it is without the full feeling, required for the child's healthy development. Tranquillizers may be a useful and temporary adjunct to psychotherapy, and sedatives may be required at night during the acute phases of the illness. Although some maturation tends to follow any depression even if untreated, there is no evidence that physical treatment furthers this maturation by changing the personality structure; yet without this change the treatment cannot be claimed to be complete.

Prevention

These patients are not easy to recognize before the birth of the child. They are usually well during pregnancy, and the labour is often easy. Because of their characteristic compliance they are pleasant co-operative women who treat the staff in the ante-natal clinic in

the easy obedient way they treated their mothers. They are 'Model Patients'. Only if a careful history and routine search is taken may it be possible to suspect which women will break down. The personality of the patient's mother and the type of relationship between them needs to be known and the patient's previous attitudes to babies may give a clue. In any case owing to their lack of overt symptoms they would be difficult to treat during pregnancy and perhaps it has to be accepted that they cannot be treated prophylactically, but only when the illness manifests itself overtly. (Mrs A. for example was happily married, enjoyed her home, seemed contented with her lot and wanted the baby. To have suggested to her when she was pregnant that she would not be able to look after her baby because she would be too disturbed mentally would have appeared unnatural. At the end of pregnancy she became a little apprehensive, but not more than many women who do not break down. Only when she undertook the responsibility of her baby did she become ill.) This difficulty in prophylaxis before the traumatic situation, precipitating the breakdown, is reached, is discussed fully by Freud in '*Analysis Terminable and Interminable*' (1937). He says 'the analyst will tell the patient about possible instinctual conflicts which may occur and will lead him to expect that they may occur in himself. This is done in the hope that the information and warning will have the effect of activating in the patient one of these conflicts in a moderate degree, and yet sufficiently for it to be dealt with. But here experience speaks in no uncertain voice—the result hoped for is not achieved. The patient hears what we say but it rouses no response in his mind. He probably thinks to himself: "That is very interesting but I see no sign of it in myself". We have increased his knowledge but effected no other change in his mind.'

The difficulty in prophylaxis in this type of case is stressed as many obstetric hospitals developing a good preventive service may come to believe that their ante-natal treatment has been inadequate or defective, if any patient breaks down in the puerperium. This leads to poor moral and even feelings of guilt in the staff which may make it more difficult for them to recognize the illness in the early stage.

I am aware that in puerperal schizophrenia the way of relating to the mother is sometimes similar, but in this paper I have confined myself to one type of case—puerperal depression, and tried to demonstrate that excessive compliance with the mother is a factor in its aetiology.

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Fatigue, work decrement, and endurance in a simple repetitive task

By WILLIAM R. PIERSON*

The patient's subjective experience of fatigue is used to limit exercise therapy in paraplegia, multiple sclerosis, poliomyelitis, and heart disease, although this is an admittedly unsatisfactory criterion[1, 6, 8, 13]. Generally, fatigue has been considered as a result of physico-chemical changes in tissue and associated with a decreased capacity for work; often it has been defined as work decrement itself[9, 11, 14, 22]. Muscio[15] and Zierler[23] have cautioned against confusing the 'feeling of fatigue' with the more restricted definition of physico-chemical changes. It has been noted that subjective expressions of fatigue are not related to work output, and one explanation for this is that the subject maintains output by increasing energy expenditure[5, 10, 20]. Bartley[3], on the other hand, has termed changes in tissue *impairment* and reserved the term *fatigue* for the personal experience. He maintains that fatigue does not depend upon energy expenditure, fatigue and impairment are independent of each other, they cannot be measured by work decrement, and that fatigue does not impair performance. These statements are based on studies involving extrinsic eye muscles and the pupillary mechanism[2]. Chapanis, Garner & Morgan[7] state that fatigue affects psychomotor as well as muscular work and that a slower reaction time in psychomotor tasks occurs as a result of fatigue.

It was the purpose of the present study to investigate the relationships of fatigue and work decrement for certain commonly encountered items of physical activity: namely, reaction time (RT), movement time (MT), and

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isotonic endurance. In this study fatigue was considered as having occurred when the subject stated that he believed his responses were becoming slower and endurance was identified by signs of obvious physical distress. Secondary considerations were the effect of boredom on fatigue and work decrement, and the relationship of RT and MT.

PROCEDURE

Twenty-six male students of the third-year class of the California College of Medicine served as subjects. All were paid volunteers and their mean age was 28·6 years (S.D. = 3·2). They were measured as to reaction time and movement time by means of an apparatus which has been previously described[19]. Briefly, it consisted of a chronoscope which was activated simultaneously with a neon stimulus lamp, a 150 g. micro-switch which stopped the chronoscope and activated another when the subject initiated the response, and a photoelectric beam placed 11 in. from the switch and whose interruption stopped the second chronoscope. Reaction time was read from the first and movement time from the second chronoscope. The subject was instructed to respond to the stimulus by releasing the switch and making a forward extension of his hand through the light beam. An audible preparatory signal was presented from 1–1·5 sec. before the stimulus. This interval is compatible with the findings of Klemmer[12], who noted that the important determiner of RT is not the immediate foreperiod but rather the distribution of foreperiods within which it is embedded. Each trial required approximately 10 sec. and the subject was tested until the observer noted signs of obvious physical distress or the subject indicated that he could no longer continue.

This point was considered the limit of endurance. Although motivation was not controlled, the fact that all subjects complained of tenderness in the area of the brachioradialis the following day is some indication that a near-maximal effort was obtained. Each subject was instructed to indicate when during the testing he was becoming bored and when he believed that his responses were becoming slower.

The data thus obtained were considered as follows: (1) *normal* RT and MT: that is, the means of trials 16–20, in accordance with the recommendations of Pierson & Rasch[17]; (2) *fatigued* RT and MT: the means of the five trials following the subject's indicating that he was becoming slower; (3) RT and MT *decrement*: the mean of the slowest block of five trials for each; and (4) *terminal* RT and MT: the means of the last five trials. The trial numbers where the subject indicated fatigue, boredom, and decrement also were recorded.

In the analyses of the data, no statistic was accepted as significant unless its probability was five per cent or less.

RESULTS

The mean scores and sample standard deviations are presented in Tables 1 and 2.

The results of the analysis of variance indicated significant differences among the scores for both RT and MT ($F = 6.79$ and 4.05, respectively). Tukey's[21] procedure for comparing individual means in an analysis of variance revealed that the samples were homogeneous as to variances and, as expected, that the scores for RT and MT decrement were significantly slower than the others. However, when these were excluded, there were no differences among the scores of the remaining groups. There was no significant order in the occurrence of fatigue, RT decrement, and MT decrement ($\chi^2 = 6.35$) and the slowing of RT had no influence on the MT scores ($t = 1.10$) and vice versa ($t = 0.04$). No significant correlation was found for normal RT or MT and the occurrence of fatigue ($r = 0.04$ and 0.20, respectively), work decrement ($r = 0.05$ and 0.31), or the limit of endurance ($r = 0.02$ and 0.24). There was a significant relationship for the occurrence of fatigue and RT performance ($r = 0.47$) but not for the MT performance ($r = 0.23$).

Seven subjects expressed boredom during the testing and for these subjects the Kendall rank correlation indicated no significant relationship for boredom and fatigue ($\tau = 0.05$) or endurance ($\tau = 0.28$). The correlation coefficient for RT and MT was 0.45, 0.54 and

Table 1. *Mean scores and sample standard deviations*

($N = 26$)

	RT (sec.)				MT (sec.)			
	Normal	Fatigue	Decrement	Terminal	Normal	Fatigue	Decrement	Terminal
Mean	0·24	0·25	0·30*	0·25	0·14	0·14	0·18*	0·15
S.D.	0·04	0·05	0·05	0·05	0·03	0·04	0·05	0·05

* Significantly slower ($P = 0.05$).

Table 2. *Trial number where phenomenon occurred*

($N = 26$)

	Fatigue	Boredom*	RT decrement	MT decrement	Endurance
Mean	93	70·4	93	98	171
S.D.	45·8	38·0	50·9	56·6	21·1

* $N = 7$.

0·37 for normal, fatigued, and terminal conditions respectively. It was 0·44 with RT decrement and 0·38 with MT decrement. The average of the five RT/MT correlations was low but significant ($r_{av.} = 0.44$, $N = 26$).

DISCUSSION

If fatigue and endurance as defined in the present study are indicative of what Bartley has termed fatigue and impairment, the results substantiate his statements that boredom, fatigue, and impairment are independent variables, and that the latter two cannot be measured by work decrement[4]. Bartley's statement that fatigue does not develop in proportion to the expenditure of energy would appear to be contradicted by the finding that slow RT scores accompany the late appearance of fatigue[3]. However, the following must be kept in mind: (1) the finding of no significant order for fatigue and RT decrement precludes the possibility of a causal relationship; (2) only a very small percentage of the variance of one is associated with the variance of the other ($r^2 = 0.22$); and (3) the speed of normal RT is not related to the onset of fatigue. The above-mentioned finding is also in disagreement with those studies which have reported no relationship for feelings of fatigue and work output in mental tasks[20]. A possible explanation may be that the 'mental' tasks required more muscular ability than C.N.S. elaboration and, as previously noted, there is no significant correlation for the slowing of movement time and the onset of fatigue. The results of the present study also support the observation of Pierson, Rasch, and Brubaker that subjective impressions of performance bear little relationship to the actual performance[19].

The RT/MT correlations noted in the present study do not substantially differ from those reported for similar age groups and using similar apparatus[16, 18].

SUMMARY AND CONCLUSIONS

Twenty-six male subjects were measured for reaction time and movement time under normal, fatigued, decrement, and endurance conditions during a simple repetitive stimulus–response task. For the population represented by the sample and under the conditions of the study, the following conclusions appear justified:

(1) The subjective experience of fatigue is not a valid criterion of the ability to perform speed- or endurance-type muscular work.

(2) Fatigue and endurance cannot be measured by work decrement.

(3) Fatigue, endurance, and work decrement are independent variables.

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An analysis of schizophrenics' interviews*

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I. INTRODUCTION

The co-ordinates of conduct, and thought disorder in schizophrenia

In a thesis of the same title the author has recently attempted a systematic assessment of 'inadequate co-ordination' in schizophrenia, employing as the theoretical framework of the investigation the postulates described by Raven (1956) as the co-ordinates of conduct. Briefly:

The generative (or 'dynamic') co-ordinates of *attention* and *intention* relate to the direction and location of awareness, on continua ranging from subject to object and from past to future. The contemporary co-ordinates of *value* and *order* relate to a person's present state of feeling and to the organization of his field of experience.

Raven's most recent exposition of the co-ordinates has yet to be published, but the reader, familiar with the classical cognitive–conative–affective trichotomy of mental functioning, will note the similarity between these and the co-ordinates. The latter provide us with concepts which inter-relate different aspects of behaviour. An individual's present *attention* and the way in which intellectual *order* is attained and maintained (equivalent to cognitive functioning) are related to his awareness of himself in relation to the past and future, i.e. his *intentional* behaviour (conation); these are related with the *values* (affection) according to which his attention or intentions are modified and upon which his orderly judgements are based.

* Carried out at Crichton Royal, Dumfries.

As expounded by Raven, the co-ordinates are not arbitrary concepts, but form a system of basic psychological principles; however, rather than attempting a fuller theoretical exposition (which would fail to do justice to Raven's conceptions) we shall justify our present use of the co-ordinates on the grounds of their relation to the familiar cognition–conation–affection trichotomy, pragmatic justification for which is afforded by their continued use.

By means of the co-ordinates, it is possible to resolve any item of normal behaviour into four components. Furthermore, it is possible to relate the widely differing aspects and theories of abnormal behaviour. For this reason, we have chosen to use them as a means of systematically analysing data obtained during the psychological interview.

Difficulties in attending have been recognized by some investigators, including Seth & Beloff (1959), McGhie & Chapman (1961) as fundamental disturbances in schizophrenia; others, e.g. Huston & Shakow (1949), Jost (1955), Kyle (1958), Topping & O'Connor (1960) have investigated response to incentives, etc.; others have been concerned with the inability of schizophrenics to form concepts, e.g. Payne, Mattussek & George (1959), Weckowicz & Blewett (1959); then again, affective disorder has been thought to be the basic disturbance in schizophrenia.

By means of a co-ordinating system of hypothetical constructs, we are able to relate rather than oppose these different viewpoints; also, to suggest a more comprehensive method of dealing with interview data.

II. REVIEW OF A STUDY OF SCHIZOPHRENICS' INTERVIEWS

In a recent article on 'Disorders of attention and perception in early schizophrenia' McGhie & Chapman (1961) refer to *a priori* observations which led them to believe that 'the fundamental disorder in schizophrenia was a cognitive one, most clearly evident in the fields of attention and perception, and that other aspects of the patients' symptomatology could be interpreted as his reactions to this basic disorder'. In order to study this disturbance further they examined the interviews of twenty-six early-schizophrenic patients. Statements made by the patients were grouped according to similarity of content. Five categories emerged which were described by the authors as illustrating: '(1) disturbances in the process of attention; (2) disturbances in the process of perception; (3) changes in motility and bodily awareness; (4) changes in the process of thinking; (5) changes in the affective process.' Statements illustrating each of these categories were given.

Some such statements, however, do not necessarily lead one to believe that the fundamental disorder is cognitive. For instance, category (3), 'changes in motility' is illustrated by the statement: 'I am not sure about simple actions like sitting down. It's not so much thinking out what to do, it's the doing of it that sticks me.' In this example, the patient's intention (or volition), his anticipation of the result of lowering himself, must, if he is to become seated, be of equal importance to his attention (cognitive activity), i.e. his present awareness of himself in relation to the chair.

Whilst we recognize the value of this study we suggest that the conclusions drawn are biased by the authors' preconceived conception of a basic cognnitive disorder in schizophrenia, which overlooks, or minimizes, the importance of volitional activity. A less biased appraisal would be represented by an attempt to study disorder not merely in terms of cognitive functioning. This would seem to be particularly desirable when the behaviour studied clearly embraces psychological components including, but not confined to, cognitive activity.

III. INADEQUATE CO-ORDINATION IN SCHIZOPHRENIA

(1) *Aims*

The psychological interview can be regarded as a situation during which a wide sample of the subject's behaviour and experience is elicited. The statements a person makes can be thought of as either normal or abnormal; in terms of the co-ordinates, they can be regarded as 'co-ordinated' or 'unco-ordinated'. In such a distinction we have the elements of a system of classification.

Briefly the aims of the study were:

(1) To differentiate between 'co-ordinated' and 'unco-ordinated' interview statements in order to see the extent to which different kinds of statements are characteristic of these patients.

(2) To assess quantitatively and describe qualitatively the inadequate co-ordination of individual patients as compared with the group as a whole and to describe any subgroups which might emerge.

(3) To compare the extent of 'co-ordination' and 'unco-ordination' before and after treatment and to relate changes with independent ratings of improvement and observations of symptoms.

Generally speaking, in thus applying the co-ordinates of conduct, our aim was to increase the value of the psychological interview.

The reliability of the method would be indicated by the extent to which changes elicited from systematic analysis of pre- and post-treatment interviews by the author were found to be consistent with the clinical observations made during separate interviews by the consultant psychiatrist in charge of these patients' treatment. Agreement between interview scores and independent observation of symptoms would also be indicative of the

validity of our conception of schizophrenic abnormality in terms of 'inadequate co-ordination'.

(2) *Procedure*

The *Crichton Royal Standard psychological interview* provides psychologists with a framework for eliciting information concerning the patient's interests, likes and dislikes, his relations with others; his attitude to the past and future, his problems and difficulties. Conversation is led over this series of topics, the patient being encouraged to elaborate his ideas, and as far as possible everything the patients says is recorded verbatim, with notes as to leading questions put by the interviewer.

Patients' interviews were subdivided into separate statements, each comprising one main sentence or clause, together with subsidiary sentences or clauses relating to the central idea. Statements were classified according to a scoring system derived from the co-ordinates of conduct.

Normal behaviour may be resolved into or analysed in terms of the four co-ordinates of attention, intention, value and order. Taking the analysis a stage further, it is possible to represent the hypothetical position of any item of normal behaviour with respect to each one of these four co-ordinates. On each co-ordinate we may locate the appropriate component of any item of behaviour (or experience) at one or another pole or at a point midway between the two. In so doing we are imposing upon it a form of classification such as may equally well apply to any item of verbal communication elicited during the interview.

Thus, the classification of an item of behaviour will be in terms of a point at one or another pole, or a point intermediate between them, on each of the four co-ordinates. In other words, each co-ordinate will afford three scoring categories, to one of which the appropriate component of normal behaviour can be assigned. One additional category for each co-ordinate will allow for the classification of any abnormal item of behaviour which, because it is 'unco-ordinated', cannot be as-signed to one or more of the normal, 'co-ordinated' categories.

In order to clarify the position let us consider each of the co-ordinates in turn and the scoring categories derived:

(i) *Attention:* normally, in attending, a person shows differentiation between *internal* and *external* objects (self and environment), or awareness of a *balanced* relationship between them; normal statements will be classified accordingly. On the other hand, statements may reflect action which is not clearly directed, which is undifferentiated in respect to internal and external objects; such statements are unco-ordinated with respect to attention and are scored as showing *undifferentiating attention*.

(ii) *Intention:* we shall classify a person's statements according to whether objectives he holds lie in respect to the *past, present* or *future*.* If, on the other hand, he is acting with *indefinite objectives*, the statement will be assigned to that 'unco-ordinated' category.

(iii) *Value:* a person's evaluations of a situation will normally be univalent, i.e. *appreciative*, *neutral*, or *depreciative*. Statements made by a person who is unable to make such evaluations, however, may be regarded as *ambivalent*.

(iv) *Order:* with regard to the normal 'field' of experience, a person's statements may be indicative of an organized field, of highly elaborated organization, or of diffuse, global impressions. Statements may thus be scored as *articulated*, or *over-* or *under-articulated*. However, the 'field' may become distorted in such a way that it appears distorted, i.e. it is '*disorganized*' and unco-ordinated statements will be assigned to the latter category.

The method of scoring adopted thus involved the fourfold classification of every statement made by the patient during interview.

* *N.B.* It is important to realize here that the psychological present may include the physical past; this obviates a weighting of statements classified as 'past' owing to the physical time separating events and the interview.

At this point, we shall exemplify the scoring procedure by quoting statements which, in our study, were classified as showing one or more of the unco-ordinated qualities, namely: undifferentiating attention, indefinite objectives, ambivalence and disorganization.

Example 1

'*I get all confused trying to make out whether I was one sister or another. I feel I should have an identity somewhere. Some part of me governing the rest.*'

In this statement the attention was *undifferentiating* between internal and external objects—self and non-self—as the patient explained. '*I felt sure I should have an identity somewhere.*' Although using the past tense his needs lay in the present at the time and, therefore, the intention was scored as *present*. His values were *depreciative*. His confusion of identity '*I get all confused trying to make out whether I was one sister or another*' represented a *disorganization* of the experiential field.

Example 2

'*I don't know what I was trying to do—trying to bring matters to a head—trying to build myself up—trying to build my character—sounds awfully stupid—trying to build up my character.*'

This statement was co-ordinated in respect to attention, value and order; it lacked co-ordination with respect to intention in that he showed *indefinite objectives*: '*I don't know what I was trying to do.*' The patient's attention was *introverted*, the value was *depreciative*, the order *under-articulated*.

Example 3

'*I'm sorry—someone says something nice to me—and I'm both elated and depressed—that's what I feel.*'

In this statement, the experience was unco-ordinated with respect to value, the patient showing considerable insight into his state of *ambivalence*. His attention was *introverted*; his intentions lay in the *present*; order was *articulated*.

Example 4

'*Once or twice I felt the bed I was sleeping in was trembling with electric power under the floor boards.*'

The behaviour described in this statement was unco-ordinated; attention was *balanced* and the intention lay in the *present*. Although his evaluation of the situation was univalent (*depreciative*), his experience of the present field was clearly *disorganized*.

For each patient it was then possible to obtain a 'profile' showing the frequency (expressed as a percentage of the total number of statements) with which his statements fell into any one of the 'co-ordinated' or 'unco-ordinated' categories. Individual scores were converted into the standard scores for each category in order to assess individual conformity to and deviations from the group trends with respect to co-ordinated and unco-ordinated qualities.

After-treatment interviews were scored in the same way as before-treatment interviews, in order to show for each patient and for the group as a whole the changes which occurred with treatment.

Comparison was made between patients' interview scores and the independent observations of symptoms; also between before- and after-treatment changes in 'unco-ordination' and independent ratings of improvement.

(3) Results

Fifty patients all under 40 years of age, clinically diagnosed as suffering from a schizophrenic psychosis and selected for major physical treatment, were interviewed prior to, and at the termination of, their 10-week course of treatment. The group consisted of 32 males and 18 females. Of the males, 6 were under 20 years of age, 17 were in the 20–30 age-group and 9 were over 30. The youngest was 15 and the oldest 36 years. Of the females, 4 were under 20 years of age, 10 were in the 20–30 age group and 4 were over 30. The youngest was 15 and the oldest was 38.

The *frequency of unco-ordinated statements,*

Table 1. *Frequency distribution of unco-ordinated statements*

Percentage frequency of unco-ordinated statements per interview

%	0.0–4.5	4.6–12.4	12.5–20.4	20.5–28.3	28.4–36.2	36.3–44.1	44.2–52.0	52.1–60.0	60.1–67.8	67.9–75.7	75.8–83.6	83.7–91.5
σ	−2.0	−1.5	−1.0	−0.5	0.0	+0.5	+1.0	+1.5	+2.0	+2.5	+3.0	+3.5

No. of patients

0	1	7	5	17	10	3	2	3	0	1	1

expressed as a percentage of the total number of statements per interview, is shown in table 1. It can be seen that the majority of patients obtained unco-ordinated scores representing from 28 to 44 % of their total number of statements.

The distribution of scores in each of the four main scoring categories as as follows:

(1) *Attention.* The highest percentage frequencies were those occurring in the *balanced* category, the mean percentage score being 73·7 % ($\sigma = 16$); *undifferentiating* attention received a mean percentage frequency of 9·82 ($\sigma = 11·5$); the category *internal* received only 9·75 % ($\sigma = 11·8$) of the total scores; and the category *external* only 6·71 % ($\sigma = 10·1$).

(2) *Intention.* The highest percentage frequencies occurred in the *present* category; the mean of these was 65·18 % ($\sigma = 13·94$); *indefinite objectives* received a mean percentage frequency of 21·25 % ($\sigma = 15$); statements scored as *past* represented 8·15 % ($\sigma = 7·9$) of the total; those scored as *future* were only 5·41 % ($\sigma = 5·5$).

(3) *Value.* The highest percentage frequencies were those in the *depreciative* category, the mean percentage score being 51·49 % ($\sigma = 15·85$); the category *neutral* received 34·68 % ($\sigma = 14·82$) of the total; *appreciative* only 8·5 % ($\sigma = 7·01$); and *ambivalent*, 5·12 % ($\sigma = 9·79$).

(4) *Order.* Here the highest percentage frequencies were those occurring in the *articulated* category, the mean percentage score being 47·09 % ($\sigma = 22·89$); *under-articulated* received a mean percentage score of 26·16 % ($\sigma = 22·8$); *disorganized,* 14·13 % ($\sigma = 14·85$); and over-articulated only 12·62 % ($\sigma = 16·71$).

The group trends, therefore, were towards: (1) balanced attention; (2) a present orientation of intentions, followed by a high proportion of indefinite objectives; (3) a depreciative or neutral evaluation of their experiences, and (4) an articulate appraisal of events.

Frequencies of co-ordinated and unco-ordinated scores were obtained for each patient and for the group as a whole in terms of the percentage of scores falling into each category.

The highest contribution to the total lack of co-ordination of the group was that of statements showing *indefinite objectives*, with a mean percentage frequency of 21·25 ($\sigma = 15$), contributed by 38 patients, *undifferentiating attention* with 9·82 % ($\sigma = 11·5$), contributed by 37 patients and *ambivalence* with 5·12 % ($\sigma = 9·79$), contributed by 20 patients.

Turning to the distribution of unco-ordinated scores for individual patients, we found that:

The most unco-ordinated patient, case no. 22, showed high scores in all four of the unco-ordinated categories. The second most unco-ordinated patient (16) gave relatively high scores, for all but disorganization. In contrast to this, the third most unco-ordinated patient (29) gave a high score in this category only.

The tendency shown by case number 16 to obtain a relatively high score for indefinite objectives and a low score for disorganization was shown by a further 22 cases. The reverse

trend occurred in a group of 13 patients, headed by case number 29. Comparable scores (mixed unco-ordination), as shown by case number 22, were given to the remaining 14 patients.

Since for the present we are concerned with examining qualities of unco-ordination as such and comparing these with the findings of McGhie & Chapman, we shall not describe in detail the comparison of the before- and after-treatment data, or the comparison carried out between the results obtained from analysis of the interviews and independent clinical observations. Sufficient, at this point, to mention that a significant agreement ($P = 0.05$) was established between the independent improvement ratings and the reduction in unco-ordination after treatment.

(4) Discussion

We have already, §III (2), given examples of statements scored as showing one or another unco-ordinated quality. In the thesis, conformity to and deviations from the group trends were discussed in relation to three patients, the most 'typical' (i.e. the patient whose profile of scores approximates most closely to the group profile), the most co-ordinated and the most unco-ordinated patient.

The profile of the most 'typical' patient departed from the group profile by maximum standard scores of -0.76 and $+0.59$. With respect to the unco-ordinated categories this difference was reduced to a maximum of 0.2. Her lack of co-ordination was expressed in statements such as : ' Dispensing was automatic, but I found myself thinking of all sorts of different things.' This statement was scored as showing undifferentiating attention. (Co-ordinated scores were present, depreciative and under-articulated.) ' I felt suddenly I couldn't—instead of putting the change out from the till I found I couldn't—I was going over and over it again.' The lack of co-ordination present here was classified as indefinite objectives. ' Previously I had the most ridiculous fears, I thought I was changing sex and one night I felt I wanted to become a catholic.' In this case the lack of co-ordination was represented by the patient's disorganized experience.

The most unco-ordinated patient, case no. 22, was almost equally unco-ordinated with respect to attention, intention, value and order. His undifferentiating attention, indefinite objectives and disorganization were reflected in attempts to explain his confusion, e.g. ' Now they've got me all mixed up—they don't understand me at all—Don't understand me at all. That's where we get to in the end—you just don't understand—you've nothing intrinsic—you've no confidence in yourself.' (Co-ordinated score was depreciative.) His indefinite objectives were further exemplified in his groping for purpose and direction: ' I went for a walk and saw the Church, and felt that was the place I had to go—it gave me a sense of purpose and direction—I went up and stood before the altar and I said to myself "You're a priest and that's a great thing".' Ambivalence was expressed in the statement: ' I'm sorry—someone says something nice to me—and I'm both elated and depressed....' Disorganization was further apparent in his account of his 'voices', telling him to: 'do this—do that—be careful, or you'll jam up the works....'

Comparison of the frequency profile of the most co-ordinated patient, case no. 23, with that of the group as a whole shows a wide deviation in three of the unco-ordinated categories, her standard scores for undifferentiating attention, indefinite objectives and ambivalence, being -0.86, -1.41 and -0.52, respectively; lack of co-ordination was present only with respect to order, her standard score for disorganization being $+0.06$ (15%). This was confined to a fairly circumscribed area of her experience, reflected, for example, in her statements: ' I was just worrying about the children; I thought someone was trying to take them away', and: ' I woke up and thought someone was going to come through the verandah.' (Attention, intention and value received co-ordinated scores in these cases.)

(5) *Conclusions*

By means of a scoring system based upon the co-ordinates of conduct, we were able:

(1) To distinguish 'co-ordinated' from 'unco-ordinated' interview statements in order to find characteristic features of the group of schizophrenic patients.

(2) To obtain individual profiles showing the extent and qualities of inadequate co-ordination of each patient and to distinguish subgroups characterized by one or another quality of unco-ordination.

From the results we concluded that:

(1) Of the unco-ordinated qualities, the most characteristic of the group is indefinite objectives, followed by disorganization and undifferentiating attention, with less than 25% of the group showing ambivalence.

(2) (*a*) Patients exhibit varying degrees of unco-ordination ranging from 90% of the total number of statements made during the interview to 7% unco-ordinated statements. (*b*) Qualitative variations enable subgroups, characterized by indefinite objectives, disorganization or mixed unco-ordination to be distinguished.

[(3) Conclusions were also drawn concerning changes occurring with treatment and agreement with independent observations.]

IV. GENERAL DISCUSSION

The results of this study lend support to the belief that disorders of attention are characteristic of early schizophrenia. Since, however, the outstanding feature of our results was the disturbance of *intentional* behaviour we would not subscribe to McGhie & Chapman's view that other disorders are secondary to those of attention. Rather, it appears that *both* of the 'dynamic' components of behaviour, i.e. attention and intention, are affected in schizophrenia. It is reasonable to suppose that disorders of the 'contemporary' co-ordinates of order and value manifested in disorganization and ambivalence, are secondary to the 'dynamic' disturbances.

McGhie & Chapman postulate that, 'Disturbances in the control and direction of motility or willed action' accrue from 'a decrease in the selective and inhibitory functions of attention'; but their very definition of this primary disorder implies the operation of more than one factor: 'selection' is related to the 'here and now' situation, but also, since choice depends upon purpose, to the individual's future objectives.

It follows then, that attempts to correlate psychological phenomena with neurological findings, even when tentative, should be made with respect to both of the 'dynamic' components of behaviour, at least.

SUMMARY

An analysis of the interviews of a group of fifty recently admitted schizophrenic patients was made in order to demonstrate a systematic method of studying interview data. It was found that disordered thinking could be assessed and compared by means of four theoretically inter-related scoring categories. Scores in these categories distinguished patients quantitatively and qualitatively with respect to their lack of psychological 'co-ordination'. Group trends were elicited and individual conformity to and deviation from these were discussed.

It was concluded that attempts to explain schizophrenic thought disorder in terms of one basic disturbance are inadequate and that a broader conceptual system is necessary.

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Reviews

Human Behaviour: A New Approach. By
CLAIRE RUSSELL and W. M. S. RUSSELL.
André Deutsch. 1961. (42s.)

To discountenance the facts of infantile
sexuality, it is no longer quite enough to shout
'Filthy!' and slam the nursery door. For some
time the facts have been established beyond
budging: all that remains is, as Freud pointed
out, to seek a way round the sexuality. The first in
this field was Jung, with his translation of sexual
material into something too misty to define but
at least nicer and more 'spiritual' than sex; and
now the Russells (as the blurb calls them) propose
a re-interpretation less fanciful than Jung's but
ultimately even more preposterous.

Not for nothing is their opening chapter pre-
faced by 'Heaven lies about us in our infancy!'.
Were the Russells' 'new approach' to have its
way, psychological science would indeed be carried
back to Wordsworth's time: what they are seeking
to re-establish is nothing less than the Victorian
figment of the sexless child. Human sexuality does
not awaken until puberty, they state—and they
add that the message 'should be inscribed in
letters of gold'.

The reader may think of refuting them with
infantile masturbation (to pick on an activity one
would have thought sexual by the narrowest and
least disputable definition). The Russells have an
answer for that: masturbation is not sex but
'pseudosex', and in children it is a response to the
anxieties of the family situation. But, if children
are non-sexual, why do they choose a sexual
expression for their anxiety? Precisely *because*,
the Russells reply, the sexual functions are not
called into use during childhood; they are waiting
there with nothing to do and are therefore prone
to abuse. (As Victorian parents might have put it,
Satan finds work for idle sexual organs.) And the
sexual content of children's masturbation fan-
tasies? The Russells will not have it, of course,
that such notions could have come out of the
children's own innocent heads, so they must come
out of the parents'; children, in order to appease
their parents, adopt their parents' sexual fantasies.
How does a child know of its parent's sexual

fantasy? The parent manoeuvres the child into
acting-out the fantasy in family life or, by hints,
puts the ideas into the child's head; the child is
adept at reading tiny, involuntary gestures in the
parents' demeanour, on the lines of 'Clever Hans'
(dear old warhorse of animal psychology) de-
tecting from his master's involuntary signals when
to stop tapping his hoof.

The Russells' book begins with an interesting
and clearly expressed preamble through recent
work on animal intelligence or non-intelligence;
then the 'automatic' responses of animals are
likened to compulsive and 'pseudosexual' be-
haviour in humans and contrasted with human
intelligence and 'real sex'; the remainder—and
bulk—of the book fills in the picture of 'pseudo-
sex'. Much of what is usually termed the sexual
activity of human beings is labelled 'pseudosex':
not only masturbation but seduction, homo-
sexuality (since 'real sex by its nature is always
heterosexual') and any heterosexual act which
fulfils a masturbation fantasy.

'Pseudosex' is evidently capable of putting up
a fight against the therapist striving to correct it.
The Russells cite a patient who spoke of a curtain
hiding things she was not allowed to see. The
patient's own association to this, namely that she
was sexually curious about her parents' inter-
course, is dismissed by the Russells as 'glib', and
the patient presently produced a further associa-
tion, concerned with her wanting to keep a pet and
being forbidden by her mother to do so. This the
Russells interpret as the patient's wish 'to see
what she herself was like before her parents began
to mould her to fit their projections', and they
comment: 'Thus are self-explorations repressed
by means of glib fantasies about prurient curio-
sity'. However, psychoanalysts may well feel that
Freud is not trounced but vindicated by this story,
and that the patient's second association did not
contradict but re-affirmed the first, 'glib' one: the
pet in the second association was a snake.

That it is desirable for therapists to correct
'pseudo-' into 'real sex' is nowhere argued but
throughout assumed. Indeed, the realness of 'real
sex' seems to rest on nothing more than a con-
ventional prejudice in favour of heterosexuality

and—more or less—monogamy. Conventional prejudice degenerates into personal preference when the authors descend to such subjective minutiae as ruling that many film stars 'conform to some masturbatory requirement' but Leslie Howard and Greta Garbo have 'real sexiness'. In general tone the book, with its sigh of relief at restoring the 'innocence' of childhood, is (in the conventional sense) healthy and jolly—there is the usual humourless insistence on the indispensability of a sense of humour; its 532 pages seem to make a fat, forthright invitation to spend a weekend at a camp for adult Scouts and Guides, with lots of good, clean, heterosexual, more or less monogamous fun and occasional outings to Leslie Howard or Greta Garbo films.

BRIGID BROPHY

Trattato di Psichiatria, Vol. 2, Part 1. By L. BINI and T. BAZZI. (Pp. xiv+814. 10,000 Lire.) Milan: Vallardi 1959.

This book is the third volume of a comprehensive four-volume work on psychiatry. The first thirty-five pages deal with the general problems of the classification and diagnosis of mental illness, while the remainder of the book is devoted to the psychiatric organic states, including those which occur in childhood. The book is excellently produced and copiously illustrated. The authors have a wide knowledge of the vast literature on this subject and cite over 1000 articles and books in English, French, German and Italian. They present the material clearly and logically, so that the book is a pleasure to read. There is no other recent work on the psychiatric organic states which can be compared with this outstanding book. The reviewer has, unfortunately, not seen the other volumes of this treatise, but if they are as good as this one, then the Italian-speaking psychiatrists are in the fortunate position of having the best modern Western European text-book of psychiatry. FRANK FISH

Grosse Nervenärzte, Band 3. Edited by KURT KOLLE. Pp. vi+228. DM. 32. Stuttgart: Thieme. 1963.

This is the third and final volume of collected short biographies of prominent neurologists, psychiatrists, neurophysiologists, and clinical

psychologists, who have lived during the last 150 years. It contains twenty-two biographies, among which are those of Maudsley by Sir Aubrey Lewis, Pierre Janet by Jean Delay, Korsakoff by Snjeshnevsky, and Binet by Pierre Pichot. Apart from the usual biographical details, each contributor gives a brief account of the contribution which his subject has made to his specialty. This work is, therefore, an extremely valuable source book, which should be in the possession of every German-speaking neurologist or psychiatrist who is interested in the origins of modern psychiatry and neurology. The book is extremely well produced and conforms to those high standards of book production which one has come to expect from the Thieme Verlag. FRANK FISH

Speech and Thought in Severe Subnormality. By N. O'CONNOR and B. HERMELIN. (Pp. 120. 25s.) Pergamon Press. 1963.

This book is an attempt at a comprehensive analysis of the diverse process contributing to cognitive defects in imbeciles; the author's outlook being largely influenced by Luria. The result may be successful as an intellectual exercise, and as such the book could find a public that is not attracted by writing from the clinician who is involved with patients.

The style is neat and lively. Undue emphasis is placed on sensory perception and the chapter on cross modal 'coding' is unhelpful and often positively misleading. Experiments on words and communication are covered well. Recall and recognition are described, but rather inadequately. Generally, the size of the samples from which startling generalizations are drawn is ridiculously small.

The bibliography of nine and a half pages is a full one, but with some rather surprising omissions, while the foreword by Professor Luria contributes little of much needed value. R. C. MACGILLIVRAY

The Student Physician as Psychotherapist. Edited by Ralph W. HEINE. (Pp. 241. 37s. 6d.) The University of Chicago Press. 1962.

In this country the need for more and better education in psychiatry for medical students is being increasingly recognized. The same need has

for many years been felt in the United States, and in several of their medical schools much more time and energy is devoted to the teaching of psychiatry than over here. In particular the dynamic approach to psychiatry which is so widespread in the United States is only gradually being introduced into undergraduate training in our medical schools.

This book provides a report on a new method of undergraduate training during which senior medical students at the University of Chicago School of Medicine are given personal experience of psychotherapy by letting them carry out individual psychotherapy under supervision. On a smaller and voluntary basis such a scheme has been in operation in this country at University College Hospital for three years.

Dr Heine and his colleagues report their methods in detail. All senior students take part in the scheme, after they have undergone training in psychiatry, with special emphasis on problems of human development and inter-personal relations, in the preceding years of their training. At the commencement of the scheme they are given eight lectures on the goals and methods of psychotherapy, during which the importance of the emotional interaction between patient and therapist is stressed. Before the student sees his patient for the first time he takes part in a preparatory conference with his supervisor and a social worker to discuss the patient's main problems and the form the relationship between him and his patient is likely to take. Thereafter the students see their patients once a week for between 12 and 17 weeks, and they are supervised weekly in groups of two to four. The many different patterns of student-patient relationship are fully described and illustrated by examples which throw light at the same time on the problems encountered in supervision and on the students' reactions to the teaching programme.

It is rightly emphasized that the scheme is not meant to be a course in psychotherapy for future psychiatrists, but that it is designed to make all future doctors, whatever branches of medicine they may enter later on, more aware of the nature and importance of the doctor–patient relationship and of how this relation can be used in the process of treatment either on its own, or, more often, in conjunction with other therapeutic measures appropriate to the various branches of medicine. This approach is similar to that used at the Tavistock Clinic in the Groups for General Practitioners.

During the three years 200 students have passed through this scheme, and the authors have collected a great deal of research data, based on their experience in supervision, on tape recordings of the students' interviews with their patients and on detailed questionnaires handed to the students and patients. The patients were also followed up after the end of treatment. The majority of the students found the scheme valuable as shown by the fact that 83 % of them thought that to partake in the scheme should remain compulsory for all senior students. 17% thought it should be voluntary. There was a definite trend towards a more positive attitude to psychiatry in general at the end of their experience in psychotherapy. Much interesting information concerning the students' attitudes to their patients and supervisors and about the psychotherapeutic process itself were obtained from the various questionnaires. The latter are reproduced in an appendix and should prove of considerable value to anyone who wishes to do research either on student training or on psychotherapy as such. With regard to the patients' progress, it is of interest that 37 % of them said they were improved at the end of treatment; 25% needed further psychotherapy. One would like to know what percentage of patients would have improved had they been treated by an experienced therapist instead. The results seem surprisingly satisfactory if one considers that the patients only had between twelve and seventeen interviews, which would appear to be a very short time for effective psychotherapy. The fact that in spite of this, significant and worthwhile changes did occur in these patients is in keeping with similar satisfactory experiences at University College Hospital.

From the students' point of view there can be no doubt that the scheme described constitutes a valuable, though as yet experimental, addition to teaching methods in psychiatry for undergraduates. It gives students direct insight into the problems of their patients and into the emotional interaction between patient and doctor, which is the essential factor in psychotherapy. At the same time, one hopes it will leave students with serious respect for the complicated and specialized nature of full-scale psychotherapy which remains beyond their reach.

The book should prove of interest not only to

teachers of psychiatry but to anyone concerned with problems of medical education or with research in psychotherapy.

H. H. WOLFF

An Introduction to Method in Psychology. By W. M. O'NEIL. (30s.) Melbourne University Press. Second edition 1962.

The purpose of this compact little book (178 pages) is to bring together, in a unified fashion, ideas which are otherwise only to be found by consulting a number of different sources. Among the subjects covered are methods of observation in psychology including experiment, case study, survey and measurement; sources of error in observation, including sampling and introspection; the nature of theorizing, including hypotheses, law, inference, explanation, and the testing of hypotheses. These subjects form a natural whole and the book fills a gap by presenting them thus. This edition embodies some revision made since the first edition of 1957. The five chapters which form the second half of the book remain somewhat concentrated reading. This is unfortunate because these chapters, concerned to show the relevance of logic and the philosophy of science for psychology, are the distinctive feature of the book. Nevertheless, it serves its purpose of introduction although an adequate bibliography would greatly enhance its value in this respect.

C. E. GATHERCOLE

Therapist–Patient Expectancies in Psychotherapy. By ARNOLD P. GOLDSTEIN, Ph.D. (30s.) Oxford: Pergamon Press. 1962.

The argument which Dr Goldstein, a research psychologist, develops in this book is that the course and outcome of psychotherapy is significantly influenced by the expectations of patient and therapist. Of like importance is the extent to which both participants in the psychotherapeutic situation entertain similar conceptions of their respective roles.

The text contains numerous references to relevant current research to which the author himself has made substantial contributions.

An obvious shortcoming of the book is its consideration of psychotherapy as if this were a uniform standard procedure regardless of the quantity and quality of contact between patient and thera-

pist. In none of the many accounts of test situations are we given any indication of the type of psychotherapy given or the formal framework within which the therapist works. It is as if the author considers all methods equally good—or bad.

It is highly likely that with the vast and increasing amount of psychotherapy being practised on both sides of the Atlantic, suggestion does in fact often play an important role as indeed it does in most other forms of treatment.

In his efforts to be comprehensive the author includes 347 references within 121 pages. However the pruning of some of this material would render the book more readable as would the elimination of such statements as 'patient and therapist roles are asymmetrical with respect to relative amount of activity'.

These considerations apart this is a thoughtful little book and several suggestions are made for further research. Of particular interest is the author's treatment of placebo effects and his pertinent reappraisal of the term 'spontaneous remissions'.

L. H. COWAN

Schizophrenia. By F. J. FISH, M.B., M.R.C.P., D.P.M. Bristol: John Wright and Sons Limited. (32s. 6d.)

This book on schizophrenia is a very welcome addition to English language psychiatric literature. Although according to the publishers it is addressed to junior post-graduates, it offers a reasonably comprehensive view of the whole subject.

It is refreshing to read a book in which the concept of schizophrenia as a group of conditions is maintained throughout. The picture that emerges is an enlarged one which corresponds more fully than usual to one's clinical experience. In the first chapter Dr Fish draws an analogy between schizophrenia and Bright's Disease. He points out that one cannot deny a patient has suffered from acute nephritis if his condition clears up without residual kidney disorder. It is equally illogical to deny the name schizophrenia to those acute psychoses with the characteristic symptoms but which exhibit complete recovery. Thus the question of schizophrenic symptomatology requires and is given a particularly full discussion and description. This subject occupies the largest chapter of the book and it is carried further in the

chapters dealing with classification of paranoid states and differential diagnoses.

Dr Fish is obviously writing from intensive clinical experience, but at the same time he has given excellent reviews of ideas on aetiology, classification and theories of schizophrenia. His erudition has enabled him to inform us not only of the views of the latter day German workers but also to remind us of those of earlier writers. It is a useful corrective to be reminded that Kraepelin's conception of dementia praecox was wider than that of Langfelt's 'nuclear schizophrenia'.

Much information has been condensed into this small book so that it can be read with profit not only by junior psychiatrists but by psychiatrists and psychologists at all levels.

W. T. McCLATCHEY

Outline of psychiatry. By LEONARD CAMMER. Blakiston Outline Series. (Pp. 398. 46s.) McGraw-Hill. 1962.

This short book by an experienced teacher has many excellent features. Based on Meyerian principles it provides a readable jargon-free account of current psychiatric thought and practice. Its material and construction will appeal to the undergraduate reader, who will readily integrate its contents with his teaching in other subjects. The causal roles of biological, cultural and psychological factors are well described, and the sections on therapy, both physical and psychological, are refreshingly practical and detailed with judicious use of case histories. Although psychopathology is included in the text, details of clinical syndromes have been relegated to an appendix, where they are summarized. This arrangement, while disturbing the balance of the book, does not diminish its value as much as one might fear. There are useful appendices giving brief biographical details of notable contributors to psychiatry, a detailed list of references, and a well-chosen, seven-page bibliography.

For its size this outline contains much useful information, and it can be recommended to medical students with confidence. Its price is high for a soft-covered book and in terms of value for money compares unfavourably with similar British texts.

I. M. INGRAM

Minutes of the Vienna Psycho-Analytic Society. Edited by HERMAN NUNBERG and ERNST FEDERN. (Pp. xxxvii+410. $10.) New York: International Universities Press.

This is the first of a three-volume series which will detail the transactions of the Vienna Psycho-Analytical Society during the years 1906–15. This particular volume covers the period 1906–08. The editors provide a valuable introduction and a short biographical account of the various members who participated in the discussions.

Everyone who is interested in the early history of psychoanalysis will open this book with eager interest and anticipation. The accounts of the meetings give a clear picture of the opinions and theoretical positions which the different members held and perhaps of equal interest is the manner in which some of them impinge themselves upon the reader's attention. Many of these names will be quite familiar while others who were actively engaged in psycho-analytical work are virtually unknown today. Representative of this group are such men as Reitler, Kahane and Meisl.

The editors point out in their introduction that many of the members did not fully understand Freud's concepts and this is certainly reflected in the discussions. Some members had a greater degree of awareness and sensitivity than others and there were, of course, those like Adler who had already committed himself to his theory of organ inferiority.

The Minutes deal with so many interesting subjects and throw up so many facets of psychoanalytic theory and technique as it was at that time that it is difficult, in a short review, to select those features which best characterize the contents of this book. Freud's contributions must certainly be given priority and there are a number of these which are worth mentioning here because they seem to the reviewer to have a value and significance for contemporary psychoanalysis. With regard to technique, for example, Freud had already reached the position where he laid the main emphasis upon the analysis of transferences and resistances. The editors comment upon this on more than one occasion.

On the theoretical side there are a number of interesting statements by Freud which show how concerned he was lest psychoanalytic concepts and theory be over-simplified and the difficulties inherent in the elucidation of normal and abnormal

mental functioning be minimized. For example, with regard to the importance of environmental influences in childhood he points out how easy it is to overestimate the importance of chance impressions. On another occasion he draws attention to the fact that the nature of the unconscious can only be obtained from an understanding of its processes. Sexuality, for example, which constitutes a major part of unconscious content, must be differentiated from the mechanisms which govern the functioning of the unconscious.

In the discussions which followed Stekel's contributions on anxiety states Freud did not avoid the difficulties inherent in attempts to understand the nature of anxiety. Even at this time there was a view—advocated most strongly by Stekel—that the concept of 'actual neurosis' was invalid. Freud argues clearly and convincingly against this, implying that such a tendency glosses over the difficulties which are presented by the clinical data. With the passage of time almost everyone has found it convenient to classify the anxiety neurosis with the psychoneuroses. This has had two unfortunate results. First it has discouraged clinicians from differentiating the manifestations of anxiety —both mental and somatic—from the other clinical data which occur in the neuroses. Secondly, it has resulted in the view that the solution of the anxiety problem will be found entirely in the psychical sphere. Freud's thinking was quite opposed to this. He believed that anxiety has important bodily origins and his concept of an actual neurosis was the outcome of this conviction.

As in any society there were members who talked a great deal and others who were loath to participate. Members made many suggestions as to how optimum conditions for discussion could be achieved but these were not always successful. It is clear, however, that Freud's principal concern was to overcome the personal differences and animosities which existed between the members. Many of his remarks are directed towards exhorting the various contributors to give first priority to the development of the subject. In furtherance of this policy he encouraged the presentation of new ideas and theories and then tried to show how they complemented or contradicted his own views. In this he was sometimes assisted by Reitler whose opinions come through very vividly in the reports of these meetings.

There is perhaps one outstanding source of difficulty in the reading and understanding of these Minutes. This is the fact that the speaker's notes are only given in abstract. This makes the discussion hard to follow at times. Nevertheless this is a small hardship and the reviewer, in common with many others, will look forward to the appearance of the remaining volumes of these Minutes.

T.F.

Letter to Editor

Dear Sir   22 April 1963

Dr Kenneth Dewhurst's review of Bateson's edition of *Perceval's Narrative*, in my opinion, does a real disservice to the readers of the *British Journal of Medical Psychology*. Apparently Dr Dewhurst completely failed to recognize the most important aspect of Bateson's presentation and his reason for publishing this old manuscript. Perceval, in his own words, gives an account of insanity that is remarkably like the double bind theory and is subject, with a minimum of inference, to a communication theory interpretation. Bateson points out that Perceval's use of paradox, for example in the nature of his auditory hallucinations, had the effect of producing a *reductio ad absurdum* situation that forced him to change.

Bateson is to be congratulated for having made use of a manuscript that existed long before current psychological theories could have influenced its author. The reader himself is able to judge from the naked text whether Bateson's conclusions are correct or not.

Sincerely yours,

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THE
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OF
MEDICAL PSYCHOLOGY

BEING THE MEDICAL SECTION OF THE
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EDITED BY
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CONTENTS

Medical psychology?*

By G. STEWART PRINCE†

A good deal has been heard in this forum in recent years of the sufferings of the psychotherapist, in the course of discussions on counter-transference. I feel that it is time that something was said about the gratifications to be gained from being a psychotherapist. Of the internal gratifications it is gradually being made explicit that the therapist's opportunity to pursue his self-development is paramount. Of the external, election to the chair of this Section is highly to be valued. I can only assure you of my gratitude. My predecessor (Sandler, 1962) made it clear that all addresses from the chair are to some extent self-revelations. It may clarify my choice of, and approach to, my subject if I give a few personal details. As a pre-clinical medical student I read a degree course in academic psychology, and subsequently wondered in some bewilderment about the relationship which I felt ought to exist between the two disciplines. Since becoming an analytical psychologist I have worked in a child guidance clinic, and for some years in a general hospital, and I have also been interested in the training of social workers.

At another level, the death of C. G. Jung, in the summer of 1961, evoked in me, amongst other reactions, a tendency to reflect on the conflict-spattered history of modern medical psychology; and to consider anew what we, as a Section, stand for, and where we stand in relation to the broad stream of clinical medicine, to which we claim affiliation in our title.

SOME REFLEXIONS ON THE SECTION

If the composition of your committee, being in equal parts psychoanalysts and analytical

psychologists, means anything other than personal affiliations, it would appear that the Section has become a container of the schism between Jung and Freud, which still reverberates (Jones, 1955; Bennet, 1961). It has changed, however, from the battle ground described by Glover as the site of 'homeric internecine struggles' (Glover, 1957), for polemic has given place to discussion and communication. It is as if the hard work of those who have striven for points of meeting has strengthened our ego, so that projections are withdrawn, but any *abaissement du niveau mental*—even that due to fatigue—can cause a reversal.

As a group we consist of doctors, psychologists, social workers and others, analysts and analysands of various 'shades' and it could probably be said that our common denominator is something called a 'psychodynamic approach'. Our discussions suggest a general acceptance of the role of psychogenesis in a wide range of mental disorders, of the importance of the unconscious (variously defined), and of mental mechanisms, transference and counter-transference. Any of these may need specific definition if our deeper feeling gets drawn into discussion. For the avoidance of clumsiness I am going to use, in this paper, fairly neutral words such as 'analytic' and 'dynamic' as if we had agreed upon a meaning for them.

We are uncertain as to what we mean by 'Medical Psychology' and a number of past chairmen have made contributions towards a definition. I will try to add to this pool.

I have often wondered what, apart from intellectual curiosity and gregariousness—and occasionally the transference—brings us together month by month. Most of us belong to other groups where 'dynamic' psychology

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is discussed. Many of us belong to a 'school' of analysis, into which goes much libido, and where our needs for contention, as well as enlightenment, should surely be met. The answer is, I am sure, complex, but I am going to be bold enough to suggest a speculative contribution.

There is a story of a rather prim, submissive woman patient saying to her analyst, 'Yes, Doctor, I am sure you are right, and that the fire is inside me...but in the interests of safety I must tell you again that your waste-paper basket is blazing!' This silly story illustrates, I believe, an occupational hazard to which we are vulnerable, both individually and sectionally, such is the fascination of the unconscious and of analytic work, and it is striking that our proceedings over the last decade indicate little interest in the kaleidoscopic march of events outside. Not since Bion's address from the chair (Bion, 1948), to which Fordham replied (Fordham, 1948), have we related our concepts to the world situation [although Foulkes did refer in passing to the possibility of our dissolution by other than psychic forces (Foulkes, 1961)], but I doubt if anything could add to the range of these two papers. There does, nevertheless, seem good reason to take stock of our relation to medicine, at this time in its history when medicine itself is showing ongoing and increasing concern about its relation to medical psychology. I would like to make an approach to this question first from an extroverted and then from an introverted point of view.

RELATION TO MEDICINE.
AN EXTROVERTED VIEW

Before such an approach can be made there are three stumbling-blocks which have to be noted. The first is the high regard which formal medicine has earned by its achievements, posing the problem of envy, which the psychotherapist should be equipped to deal with. The second is related, namely the 'scientific inferiority complex' of dynamic psychology which still bedevils us, although the relations between dynamic psychology and empirical

science were defined implicitly long ago by such scientific authorities as Whitehead, Eddington and Pauli (Whitehead, 1928; Eddington, 1928; Jung & Pauli, 1955). The explicit definition by Woodger in his strangely neglected methodological essay *Physics, Psychology and Medicine*, written with the weight of a biologist, a symbolic logician and a medical teacher should have laid this ghost (Woodger, 1956), but we had to be reassured again by the psychologist Farrell two years ago (Farrell, 1961) and at the beginning of this year by Lord Brain (Brain, 1963).

The third is the identification with medicine, a problem for all of us who came to dynamic psychology through medical training. This may have been to some extent resolved in our training to be psychotherapists, but it seems doubtful if full resolution is possible. Both Freud and Jung were at pains to achieve it, but both remained physicians to the end, and it has been pointed out that that centrepiece of the psychoanalytic setting, the Freudian couch, is a relic of the anatomist's dissecting table.

On the surface, there are good reasons to believe that our 'dynamic psychology' has increased in stature in the eyes of the medical world. In the paper just mentioned, Lord Brain wrote, 'Only those who can look back far enough can fully appreciate the great progress in knowledge, therapeutic capacity, influence, and status which psychiatry has achieved...' having dealt comprehensively with the problem of the many languages of psychiatry. The core of his argument is of sufficient importance to demand quotation '...the task of reducing human behaviour to one systematized set of concepts is, if not insuperable in itself, at any rate probably beyond the horizon of the present century. If this is so, it should not be surprising to find a variety of languages in psychology, each of which gives a certain unifying account of phenomena, and possesses a certain degree of internal coherence, but which is so different in its structure from the others that complete mutual translation is impossible.' If we could accept this authoritative dictum I feel that

much energy could be freed from preoccupation with our guilt about ignorance, and turned to constructive use.

The influence to which Lord Brain refers could hardly be better illustrated than by the fact that the recent Reith Lectures were given by a psychiatrist, and in their content owed so much to psychodynamic theories (Carstairs, 1963). A leader in the current number of the *British Medical Journal* states that 'the lectures had a therapeutic impact', and goes on to imply that the central tenets of psychoanalytic theory are by now generally accepted in medicine (*Brit. Med. J.* 1963).

However, we have learned to regard superficial evidence with suspicion, and Lord Brain's assessment may be over-generous simply because he is an unusually informed and sympathetic medical observer of the psychiatric scene. It may be that a more accurate general picture of 'how the others see us' is given by the distinguished Irish physician, Counihan, in his Presidential Address to the Section of Medicine of the Royal Academy of Medicine in Ireland two years ago (Counihan, 1961). His theme is holistic medicine, but his comments indicate a good deal of ambivalence towards psychotherapeutic theories, and he states 'It is very difficult for the average physician to place any reliance on hypotheses based on a patient's account of his dreams'.

I have often wondered what direct impact our sectional deliberations have on the medical world outside, and therefore cast about for some method of obtaining evidence about this. I decided that information on the demand for our *Journal* in the London teaching hospitals would give the most reliable indication, and had the idea that it might be possible to compare this, over a fixed time period, with the demand for another medical periodical of likely comparable importance to the general physician. I put this scheme to a librarian, who assured me that it would be difficult but not impossible to execute, and put me in touch with a teaching hospital librarian. It was soon clear that execution was not at all difficult. No London teaching hospital library

takes the *Journal*, although one tried it for two years and apparently found it wanting in appeal. Inquiry at the library of the Postgraduate Medical School of London revealed that again it is not taken.

Reflecting that among the more than five thousand medical periodicals ours had little chance to catch the eye of the busy physician, I made similar inquiries with regard to the book *Pain and Pleasure*, by the American psychoanalyst, Szasz, which will be familiar to many of you. It deals, in an unusually and attractively clear manner, with such topics as the meaning of pain, pleasure and bodily feelings, phantom body parts and phantom pain, hypochondriasis and the philosophy of the question, 'Where is the pain?' (Szasz, 1957). These matters are surely the daily concern of the physician, and even the surgeon, but again this book is not on the shelves of the libraries concerned, and thus a prediction made of its neglect by medical readers (Prince, 1958*a*) is more than fulfilled.

We can assume therefore that the centres of medical learning are unlikely to be influenced by reading of our deliberations, but it is perhaps more important that they are gradually being infiltrated by analytically trained psychiatrists, psychologists and social workers. Until recent years, with a few notable exceptions, the ponderous doors of our teaching hospitals were closed to analytically trained psychiatrists, no matter how respectably qualified from the medical point of view. This position is gradually changing, and a number of analysts are now working in these hospitals, many accorded consultant status, as well as those working in non-teaching hospitals and out-patient clinics of varying structure and aim.

This is important not only because it makes available, in the hospital setting, analytical treatment for some patients who might otherwise be denied it—I think here of H. S. Klein's description of the successful psychoanalysis of a severe anorexia in a young child in hospital (Klein, 1961)—but also because of the effect that such a treatment can have on the medical and nursing staff who witness it, and on the

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whole emotional climate of a ward. This applies even where the setting imposes drastic limitations on treatment technique, as I can illustrate with a clinical anecdote.

Clinical anecdote. I was asked to see a young adolescent girl who had been admitted to the children's ward unconscious, with a tentative diagnosis of encephalitis or similar cerebral catastrophe. Investigations proved negative, and she fairly quickly recovered consciousness. When I saw her she lay prone, with her head sideways on the pillow, looking ill, pale and drawn. She made no response to a greeting, but shot occasional glances towards the corner of the ceiling, showing anxiety and suggesting that she was hallucinating. She made frequent hunching movements of her arms which suggested that she was trying to cover her trunk, and when I interpreted this to her she turned her head to look at me, became more alert, and then cried in an agonized voice—'I messed meself'. (She had in fact soiled and wetted herself just before losing consciousness.) After this she again became vague and withdrawn, and the interview had to be left here for practical reasons. However, this fragmentary clinical picture, together with a detailed history, suggested that she was showing an hysterical regression. The ward sister reported that after this short interview the girl, Sara, had gradually become more alert, had looked at her in a friendly way, had eaten lunch when it was offered, but had become frightened and seemed to 'go away' again when she attempted to bed-bath her. I was faced with the problem that I only visited the hospital once a week, was heavily committed there, and yet wanted to help Sara. The sister was concerned about the child, and readily agreed to pay her special attention, to observe her behaviour, and to make note of anything she might say. The following week brought an interesting report. Sara had become more normal, though still odd. She paid little attention to the children around her, but showed increasing interest in the sister. She did not respond to efforts to get her to talk, but twice out of the blue had addressed sister. On the first

occasion she asked, 'Did you know my Granny died?', and on the second, in a babyish whine, 'When are Mummy and Daddy coming?'. In fact her parents had visited daily, but during these times Sara became again withdrawn and appeared to resent their anxious efforts to get her to talk. The most dramatic behaviour had been a terrified response to the suggestion that she should have a bath.

Armed with these clues it was possible to have weekly psychotherapeutic interviews with Sara. Starting with her obvious anxiety about her body led to her guilt about her early menarche and anxieties about a florid oedipal conflict, catalysed by the recent death of her maternal grandmother. Her conflict between dependence and independence was prominent, and also her wavering sexual identification, her feelings of physical inferiority, and her envy of older, more attractive girls.

As her ward behaviour became more normal she talked increasingly to the sister, and dropped clues about her problems thick and fast, as if she too felt the pressure of time on the situation. She also began to use the sister as an ancillary therapist, telling her of her critical feelings towards her parents, her wish to be attractive, and so on. After ten weeks of treatment Sara appeared to have recovered, looked well and happy, and was able to return to her home.

It is with the repercussions, however, that I am concerned here. Several of the ward staff took a keen interest in Sara's changing behaviour, and in her relationship with her parents as shown during visits, and commented sometimes with remarkable shrewdness. The senior ward sister, hitherto politely sceptical about any usefulness in psychiatry, became more positive and began to consult me informally about the emotional implications of ward procedures, investigation techniques and painful treatment measures for her charges. The paediatrician in charge showed a changing attitude less directly. Previously he had asked for my assistance in an odd way. Having recorded his history and findings in

a case of doubtful diagnosis, he would add his instructions for further investigations as follows: (1) Chest X-ray, (2) E.S.R. (3) W.R. (4) G.S.P. (author's initials). I did not mind this, but was amused to find that after the case of Sara he sometimes put G.S.P. at the top of the list. More important, our communication with each other increased, we joined in a small research project, and he shortly asked me to show the film *A Two-year Old Goes to Hospital* to a post-graduate group, and to conduct the ensuing discussion.

Another important outcome of the entry of analysts to teaching hospitals is its potential influence on the teaching of psychology to medical students and graduates. A number of committees have made strong recommendations on this subject over the last twenty years, but there seems to be little momentum for their implementation, and still a good deal of uncertainty as to what should be taught, by whom and how. In his Presidential Address to the Psychiatry Section of the Royal Society of Medicine a few months ago Dr Henry Wilson described his experiment in teaching psychology to medical registrars, chosen as a prestige group who would influence their juniors. He concluded that ideas on this sort of teaching were 'woolly', and in the ensuing discussion no less than three professors of psychiatry sounded a discouraged note about their experience.

The contrast with the position in regard to the training of social workers is marked. In their psychological education psychodynamic theory has always been given a central place. In the course with which I am associated classical psychoanalytic personality theory is taken as the guiding theme, while in the description of each stage of development the modifications advocated by Jung, Adler, Klein, Fordham, Fairbairn, Horney, Fromm, Sullivan and others are mentioned. In addition to a scheme of development from conception to the grave, psychodynamic theories on pregnancy, childbirth, illness, courtship and marriage, atypical family situations, deviations of sexual development and group psy-

chology are taught and this course is carefully integrated with the case-work supervision and with lectures on social psychology (Prince, 1958b). A follow-up inquiry (Lewis, 1958) suggests that it is successful, for statements from the students of the first three years of the course imply that they had been able to integrate the teaching into their lives and work, and a surprising number referred spontaneously to awareness of change in themselves. To quote one: 'I had not expected the personal gains (or indeed recognized the need for them) but I feel that I have been given an opportunity for the dissolution of old, inflexible patterns, and so for the beginning of fresh personal growth and development, which I could have gained in no other way.' It may be argued that medical students are a different kettle of fish, and that the powerful social structure of the teaching hospital may limit the teaching of dynamic psychology, but the challenge is there and there is room for ingenuity and experiment.

Mention of hospital social structure recalls another important trend. Since the Wharncliffe and Northfield experiments of Bion and Rickman (Bion, 1961), the application of analytical concepts to the problem of patients in hospital has gained great momentum, and the wards of many mental hospitals have been swept by a wind of therapeutic vigour, stimulating to patients and staff alike. This is made particularly significant by the current health legislation which encourages the increased use of general hospital beds for psychiatric patients. It seems likely that there will be some collision between the *mores* of the traditional general hospital and the 'therapeutic community' orientation of psychiatry. This highlights the value of the projects that the Tavistock Institute of Human Relations has undertaken over the last ten years, of which that recently reported by Menzies serves as a model (Menzies, 1960). This study was initiated by a London teaching hospital (sic!) 'which sought help in developing methods of carrying out a task in nursing organization'. Menzies and her co-worker responded by

collecting data 'within a socio-therapeutic relationship in which the aim was to facilitate desired social change'. By focusing on the techniques used in the nursing service to contain and modify anxiety, and applying Jaques's concept of socially structured defence mechanisms (Jaques, 1955) it could be seen that these techniques were dominated by the paranoid–schizoid type of mechanism described by Melanie Klein (Klein, 1952, 1959), so that the changes which could be made were symptomatic, based on the strengthening of defences. The current issue of *Human Relations* is devoted to descriptions of similar studies, applied to hospital management, power-oreintations in the mental hospital, and so on (*Human Relations*, 1962).

Another ingenious application of analytical insights to a serious hospital problem, this time that of the chronic attender at out-patients, is described by Heasman (1962). He demonstrates convincingly that the condition of institutional neurosis (Barton, 1959) is not confined to the long-term inmates of mental hospitals, but manifests itself in larval form in the addict to out-patients, with whom the hospital staff collude. Solution of this problem refers us back to the question of balance in medical education.

Another important influence on medical thinking lies in the many studies, completed or under way, on the psychology of illness, of pregnancy and childbirth, and of bereavement and mourning, although, with regard to the last-mentioned, it is noteworthy that it was a medical social worker who first published an account of her use of dynamic psychology to construct a general technique for helping those who have difficulty in achieving healthy mourning (Snelling, 1955). On a large scale the work on maternal deprivation (Bowlby, 1951), in spite of much critical attack, has had great impact on paediatric practice and hospital administration, while on a small scale the recent paper by Plank & Horwood (1961) is a model of what can be done in a tragic situation by way of research and therapy, in the absence of formal analysis.

All this might be called the infiltration of dynamic psychology into medicine, but I must also refer to what may be called its diffusion. By this I mean the sort of work which is best known in this country by the experiments of Balint and his colleagues at the Tavistock Clinic in using analytical insights and techniques to help general practitioners (and others including trainee psychiatrists and social workers) in their handling of psychiatric patients (Balint, 1957). The publications of the Family Discussion Bureau (Bannister, 1955; Pincus, 1960) give a good indication of how such methods can be developed. Similar experiments have been going on for some years, in London mainly centred on the Child Guidance Clinics. The purist may object that this represents a dilution, rather than a diffusion, of dynamic psychology, but those of us who have taken part have met frequently to compare notes, and some agreed on the value of the experiment. There is also agreement on two specific points. The first is that the learning is two-way; I certainly have learned a good deal from experienced health visitors who have had close and continuing contact with hundreds of mothers and their small babies. The second is that non-medical agents, such as health visitors and probation officers have to carry a great deal of the burden of mental ill-health in the community, and deserve what help we can give them.

It would be avoiding an important issue to leave this over-view without comment on the special problems of our relation to paediatrics. Seven years ago the paediatricians Leys and MacKeith addressed the Section on 'The Psychological Factor in the Work of the Paediatrician', when MacKeith told us 'it seems to me that you have realized that you are responsible for helping us to go forward in one big field of our work'. This is a far cry from the attitude of the paediatrician Brennemann, who warned the American Pediatric Association of 'The menace of psychiatry' (Brennemann, 1931), but, in spite of a number of joint working groups in which paediatric-

ians and psychiatrists have aimed at liaison, the problems of such liaison have not yet been solved. At the meeting in 1956 Winnicott, if I remember him rightly, dropped a characteristic hint, saying that he who wanted to do psychotherapy had to have psychotherapy—and have enough—but this has not been widely taken up. Further, any consideration of this question has to take into account the dwindling demand for somatic paediatrics, and the fact that both the paediatrician and the analytically trained psychiatrist can claim a vested interest in the child.

From the extroverted point of view it would seem that medicine and dynamic psychology are in a state of increasing interaction with each other, and perhaps we can do no more than to await the outcome with interest. Nevertheless, there is a residual psychological problem involved which should not be glossed over, as Jung emphasized nearly twenty years ago in his essay 'Medicine and psychotherapy' (Jung, 1945).

THE PSYCHOLOGICAL PROBLEM

In that essay Jung outlined the difference in attitude between the physician and the psychotherapist to such fundamental matters as anamnesis, diagnosis and therapy, and stated: 'But it is extremely important, in his own interest, that the psychotherapist should not in any circumstances lose the position he originally held in medicine, and this precisely because the peculiar nature of his experience forces upon him a certain mode of thought, and certain interests, which no longer have— or perhaps I should say, do not yet have—a rightful domicile in the medicine of today.' Fordham has recently stated the problem succinctly as 'a broad division between those who apply the classical methods of medicine as a whole by asserting that mental disorders are disease processes for which suitable treatments can be applied, preferably biochemical, and those who consider that in these states it is necessary to take the whole person into account' (Fordham, 1961). Pointing out

that the dynamic psychotherapist considers some mental disorders as attempts at self-realization, he goes on, 'the analytic method involves the physician in a relationship with his patient which is both arduous and intimate, charged with affect in which the patient attempts to embroil him. It is a relationship which the general physician or surgeon seeks to dispense with by treating the diseased bits of the patient, and leaving the personal implications on one side to be taken care of by nurses or relations.'

Each of us will have struggled with this central problem in his own way, and there will probably be general agreement that it will remain the crucial factor in our relations with medicine, whatever changes may occur in social, cultural or political fashion between us.

For me it is natural to approach such a problem from the introverted standpoint.

RELATION TO MEDICINE.
AN INTROVERTED VIEW

In seeking to understand such a problem, it is natural for the psychiatrist to turn to history, and for the analytical psychologist to refer to myth. Here I am indebted to Kerenyi for his monograph *Asklepios*, which he subtitles 'Archetypal image of the physician's existence' (Kerenyi, 1960). Only the essence of this myth, some 3000 years old, can be outlined. Asklepios, son of a dark, centaurian father, has his birthplace in association with a river, Lethe, meaning hiddenness and seclusion. He is born from the funeral pyre of his mother, Koronis, the dark beauty, who is also called Aigla, the luminous. He serves his apprenticeship in medicine under Chiron, the divine originator of the healer's art, according to the Iliad, whose features are important enough to merit further attention. Kerenyi says of Chiron, 'his nature combines the animal and the Apollonian, for despite his horse's body, mark of the fecund and destructive creatures of nature, he instructs the heroes in medicine and music'. Further, Chiron, the healer, suffers from an incurable wound, so

that his world, with its inexhaustible possibilities of cure, remained a world of eternal sickness.

·After his dark beginning, and his birth between life and death, Asklepios shows himself as a sun god 'the procreative Apollo flaring up from a mother both dark and light', and this paradox is repeated in his emblem (and epiphany) the snake. While this is obviously chthonic in character, the species sacred to Asklepios was in fact a tree snake, *Coluber longissimus*, associated with the palm tree which is in turn related, by its Greek name *Phoinix*, to the reddish colour of the sun. The *caduceus*, snake-and-staff emblem, still surrounds us today (although now used mainly, and with little effect, for repelling importunate traffic wardens!). The meaning of the snake, in its mythical context, Kerenyi gives as follows—'life at the threshold of death, a hidden force, dark and cold, but at the same time warm and radiant, that stirs beneath the surface of the waking world and accomplishes the miracle of cure'.

The two sons of Asklepios are important; one was Machaon, the first surgeon (whose name means the slaughterer); the other Podaleirios, who healed invisible ills, including those of the soul, a hint at the beginning of specialization, and at the origins of our medical psychology.

Two final points about Asklepios. He too, like Chiron, is inflicted with an incurable wound, and he was the ancestor of Hippocrates, whose name repeats the horse motif, and to whom many of the most scientific of today's doctors pay at least titular tribute.

What commands attention as the recurrent theme in this picture of Asklepios is his position between pairs of opposites—between birth and death, sickness and healing, dark and light, below and above—so that the imagery seems to emphasize his reconciling function. There is interesting confirmation of this interpretation in a recent, little-known paper by Layard, which he calls 'The meaning of medicine' (Layard, 1961). From a very different starting-point, namely etymological inquiry after the derivation of the word *remedy* in Partridge's *Origins* (Partridge, 1961), Layard found himself referred to the word *medical*, and saw that the connexion lay in the syllable *med-*, meaning mid or middle. Thus, goes his hypothesis, *medical* (Latin, *medicalis*) derives from *medius*, meaning the middle thing, so that *medicus*, a physician, is one who knows how to unite opposites. The important words are derived from the Latin *mediare*, meaning to cut in half or be in the middle of, in a word, to *mediate*.

Here for the moment I must leave the myth of Asklepios, but before turning from Kerenyi's book I would like to remark on two things. The first is the relation between medicine and religion for the Greeks. Kerenyi emphasizes that the gift that Asklepios handed down was neither a religious nor a philosophical knowledge 'but rather a familiarity, which can never be acquired, with sickness and the process of recovery'. None the less, in pre-Homeric times there seems to have been no differentiation between religion and healing, while by the time of Hippocrates, around 500 B.C., the distinction is clear. For instance, the Island of Kos had become famous for its medical school, and Kerenyi suggests the following line of historical development—first the school of physicians at Kos achieved a high level of medical science; next, a turn towards religious depth, originating at Epidauros, spread to Kos itself; finally, in the imperial age, the medical element regained its predominance, even at Epidauros. That this enantiodromia between medicine and religion has continued is shown by the fact that more than 200 of our British hospitals bear saint's names, and that special services for physicians are still held.

The other point illustrates a similar pattern of evolution. In the pre-Homeric period the split between body and mind does not appear, or, perhaps it would be better to put it, had not been invented, to defy final solution still. By the time of Homer this problem seems well established. Onians points out, in his *Origins of European Thought*, that by then the phrenes,

or lungs, were conceived of as being capable of undifferentiated psychic activity, while they also contained the thymos—the stuff of mind or consciousness (Onians, 1951). By the time of Hippocrates the split is quite firmly established.

From these starting-points I would like, with some imaginative licence, to try to trace the psychology of the development of modern medicine as one would that of the individual, using the models of analytical psychology. It will be clear from both that by the time of Homer a disruption of primal unity has taken place, reminiscent of Fordham's theory of the origins of the ego in childhood (Fordham, 1957). I may remind you that Fordham postulates a primal state of wholeness, an original self which has the property of spontaneous deintegration. This deintegration is a pre-requisite for the development of consciousness, and is followed by periodic phases of integration and deintegration. From the deintegrates (fragments of ego-consciousness, or ego nuclei) a single central ego is gradually formed through the integrative action of the self. From the psychological viewpoint the history of medicine can be illuminated by applying this concept of phasic integration and deintegration, and this is particularly well illustrated in the history of controversy over the body–mind duality, for instance as appraised by Reeves from Hippocrates through to William James (Reeves, 1958).

Other psychic activities besides those of the self contribute to the growth of the ego, and in particular the instinctual aspects of the archetypes which have been so thoroughly studied by psychoanalysts. I wish to refer to another aspect of archetypal influence, also phasic or enantiodromic in mode of operation, namely the conflicting influences of the masculine Logos principle and the feminine Eros. The elements of scientific thought discernible in classical Greek medicine indicate the dominance of the Logos principle, which is characterized by its dynamic, discriminating and intellectual mode. By the end of the fourth century, however, medicine in common

with the rest of science was overwhelmed by the serial influence of Stoicism, Neoplatonism and finally Christianity. St Augustine is often quoted in evidence for the influence of Christianity on medieval thought and he makes his position with regard to medicine quite clear, stating: 'What benefits the body is called medicine—what benefits the soul, discipline.' Adler has described this period in the history of western thought as containment in the Mother archetype, characterized by its passive, feminine features (Adler, 1945). With the Renaissance came the eruption of the repressed, masculine, Logos side, best symbolized for science by the Copernican revolution in astronomy. This Logos domination has continued, bringing among other things the spectacular advances of modern somatic medicine, but also that crisis of values with which Jung preoccupied himself since 1918 (Jung, 1918), and on which both Adler and Fordham have addressed this Section (Adler, 1945; Fordham, 1948). It is significant that it was two physicians—Freud and Jung—whose pioneer researches opened up the possibility of restoring balance and averting the still-present danger of one-sided development, and that Freud's approach was through the instinctual unconscious, while Jung focused on the psychology of the Mother archetype.

The danger, from the standpoint of the world situation, needs no amplification. In relation to contemporary medicine it is no less important.

Along with phenomenal success in discovery and application over the last hundred years has come the possibility of chemical and bacteriological warfare. The high professional and ethical standard of the average physician has its shadow in the medical atrocities of the Nazi prison camps. Advances in medicopsychological techniques have relieved much suffering, but also provided the rationale for the planned degradation of the personality on a massive scale, as described by Merloo (Merloo, 1957) and Bettelheim (Bettelheim, 1961). Even the tremendous advances in therapeutics which have been the highlight of

medical progress in the last thirty years or so have brought with them the epoch of the 'philophysic', as the physician Evans has recently called the addict to medicines, an epoch when millions of pounds per year are spent on medicines, many of them useless if not harmful, and nearly 2000 such are supplied by proprietary drug firms for prescription in general practice. Evans frankly admits that this addiction 'has been contracted with the connivance of the medical profession', based on the false therapeutic philosophy that 'To heal is to treat, and how else is the physician to treat an illness except through dispensing medicines' (Evans, 1962).

It is, however, in the relations between patients and profession that the unease shows most clearly. To instance a dramatic and hard-won technical advance, the possibility of transplanting an organ desperately needed by the patient from a human donor has become known to the experts as 'spare-part surgery', which surely reduces the patient to the status of a rickety machine. The doctor–patient relationship has, for other reasons, always contained ambivalence, but only the 1960's could have produced the amusing 'modern myth' by the American humorist, Capp. In this he fantasies that doctors have become too wealthy to leave their offices or estates, except to attend conventions on medical politics. So they become curiosities, only to be seen by the 'natives' in serials on the television screen. Surgical advice is given by telephone, the era of 'do-it-yourself-surgery', and by 1975 it is discovered that there are no more doctors in America. They have all moved to Switzerland because of the tax situation, leaving computers to answer their telephone. Legalized computer medicine is the logical outcome (Capp, 1962). This fantasy does not seem so bizarre in the light of the recent advocacy of the superiority of machines over people for teaching! The temptation to project the whole problem across the Atlantic, and to despise the materialistic medicine of America may be considerable, but here at home, where medicine is better than it has ever been, there is a persistent disquiet amongst doctors and patients alike, and recent rumours, inadequately denied, that patients in teaching hospitals are submitted to experiments, rather than treated according to their needs, should demolish complacency.

To quote a trenchant phrase from Fordham's address to the Section, 'Man has dismembered himself in order to create civilization' (Fordham, 1951). It could be said that the original wholeness of medicine, embodied in the figure of Asklepios, has been disrupted to allow the building up of the 'ego' of medicine—that great *corpus* of knowledge which is one of the finest achievements of *homo sapiens*. Only the dominance of the Logos principle has made this achievement possible, but that at the threat of imbalance. The Eros principle remains as long as the healing intent is present, but if that should fade—or to put it another way, if the physician departs from the ancient precepts of Hippocrates, then it is conceivable that medicine, like Science, could claim indifference to human suffering—a disintegration.

Psychologically it seems sound to see the position as a 'crisis of middle life' for medicine. It may, like many a successful individual, have now to turn and try to integrate its neglected, 'inferior' side, its Eros-aspect. This is indeed what the profession is expressing in its current avowal of concern for mental health, but experience of the individuation process in the analysis of patients warns us that it is a slow and tricky business. Medical psychology, it seems to me, is to medicine as the underground Gnostic movements were to medieval Christianity. In them the Logos principle predominated, as a counter to the maternal archetype. With medical psychology it is the Eros principle, concerned with relationship, feeling and value. Its modern starting-point, with Freud and Jung, was with the exploration of the maternal, instinctual unconscious —the dark, chthonic nether world of Asklepios. With them also the theme of 'the wounded healer' was taken up, for there is fact of Freud's 'very considerable psycho-neurosis'

(Jones, 1955) and of Jung's fear of his own destructiveness (Fordham, 1962), with the consequent insistence on the personal analysis of the analyst.

It has taken medicine three thousand years to reach its present state of 'ego-development'. If it is now turning to the process of individuation, this too will take time, in the historical sense. A gradual integration of our 'medical psychology', Eros-based, may compensate for one-sided development, and assist in the task for medicine of re-establishing its wholeness, without losing its hard-won 'consciousness', our medical knowledge. There is good reason to feel that its 'ego' is strong enough to stand the essential conflict of the opposites. The nearer it approaches its wholeness the more it will regain the reconciling, mediating function symbolized in the figure of Asklepios, a function which meantime may have to be carried partly, no matter how inadequately, by 'medical psychology'. At the beginning of this paper I promised a speculation on why we value the Section, and to make it I have taken a final glance back to the Greeks. The writings of the Koan school of physicians, commonly accredited to Hippocrates, include a treatise on 'Decorum' which says: 'Wherefore...transplant wisdom into medicine, and medicine into wisdom. For a physician who is a lover of wisdom is the equal of a god.' By this standard none of us expects imminent deification, but in our adherence to the Section we may be trying to relate to the archetype of the physician's existence.

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Untreating—its necessity in the therapy of certain schizophrenic patients

By JOSEPH D. LICHTENBERG*

The application of psychoanalytic insight and verbal techniques to the therapy of schizophrenic patients introduces, as do almost all important advances in therapeutic methods, certain inherent dangers of misuse. These techniques range from attempts to follow with little or no modification a classic analytic procedure (Boyer, 1961) to the aggressive interventions of John Rosen's *Direct Analysis*. What all these methods have in common is that the agent through which much of the treatment is intended to take place is clarifying or interpretive interchange (of course, in a carefully arranged general therapeutic and interpersonal setting). The use or withholding of this type of verbal interchange may have a variety of effects on all the components of the patient's psychic apparatus. The effect most concerned with in this presentation is the effect on the narcissistic reservoir of an already disorganized ego. The premise I wish to develop is that for a variety of reasons to be discussed later, the main agent of the therapist, clarifying and interpretive verbal interchange, sometimes becomes, from the patient's point of view, a weapon used to increase his narcissistic mortification. The result of this further wounding is that other means of therapeutic approach become necessary.

To help clarify this premise, I shall refer to two other situations in which the dynamics are clear: (*a*) a second analysis of a neurotic patient after a stalemated earlier one; and (*b*) a second hospitalization of a schizophrenic patient after the routine use of 'admission' ECT.

The analyst attempting the second analysis of his neurotic patient is aware that very likely one component of the stalemate under usual

circumstances was the inability during the first analysis of the patient to freely express his feelings and thoughts, and that this is apt to be related to his feeling of narcissistic hurt when he did so. On top of this, the failure of the analytic effort itself represents a further loss of self esteem. The neurotic patient still motivated to resolve his problems will approach re-analysis with a degree of wariness that presents the analyst, almost from the beginning, with a pre-formed transference reaction that requires active and very sensitive handling to enable the patient to quickly differentiate between his prior failure situation and a current fresh attempt. The dynamic need to differentiate between the old and the new is the same as with the schizophrenic patient. However, the method of doing so can be quite different, in that the neurotic patient, with his ego functions intact, can test reality efficiently enough that clarifying and interpretive elucidation of the *patient's* conflicts can continue to be the main therapeutic tool.

The therapist working with a schizophrenic patient whose regressive clamour for help had been met by a routinized use of ECT by people with whom he had no opportunity to form a human relationship is faced with a situation which cannot be dealt with by an interpretation of the patient's dynamics alone. Specific and persistent reassurance that an untherapeutic attack will not be repeated is required. However, in this instance the therapist can still work with his patient in the verbal sphere because the traumatic agent was not miscarried verbal communication but mechanical handling. Regardless of the degree of psychotic disorganization, an approach of primary care and simple reassurance can be

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followed and our tool of verbal communication will still offer the patient hope.

The situation on which I wish to focus in this paper is different from each of these examples. These schizophrenic patients were not handled by a routine method but on the contrary every conscious effort was made to form a relationship with them and to use this relationship to help them gain insight into their internal conflicts. When this not only failed to help but because of repeated hurts actually drove these patients into heightened distrust, we were not always able, as with a neurotic patient, to let a period of time go by and have the patient want to return, hurt and saddened, but realistically aware of his illness as *his*, regardless of any wounds or grudges he may still harbour. The schizophrenic regression and disorganization may have become so chronic that such a realistic appraisal was impossible and the patient so gun shy of 'understanding his difficulties' that no reassurance of a new therapist that this is a new and hopeful situation in which to get well by insight can have any effect other than drive the patient into further regressive modes of avoidance.

At this point an example of the miscarriage of the treatment of such a patient in a fine hospital by an inexperienced but otherwise skilled person might further clarify the clinical phenomena to which I am referring. Mrs R. was a 26-year-old married woman who had her first psychotic episode after the birth of her first child, a son. She had grown up in Germany and came to this country after World War II. Her husband was a somewhat schizoid physics graduate student. At the time of her admission to the hospital, Mrs R. was hyper-active, suspicious, and had somatic delusions. In the admission interview, she stated: 'I'm not going to talk. I have tried to talk to psychiatrist before and it was a waste of his time and my time.' Since she was very hyper-active and only a few days post partum, there was serious concern about her exhausting herself and she was placed on a tranquilizer. Her therapist gave her careful physical care and astutely separated from her many somatic complaints, ones that indicated a urinary infection, treatment of which was promptly instituted. Mrs R., within several weeks, became less hyper-active and more generally integrated in thought and behaviour. As far as her illness was concerned, she used denial and somatic preoccupations as her main defences and refused any other discussion of her plight for the first 6–7 weeks of hospitalization. At this time she very tentatively entered into a generalized discussion of mental illnesses in families, referring obliquely to her sister, a physician, who subsequent to a psychotic break was working as a household helper. Shortly after this, her therapist decided to take advantage of the patient's increased openness to confront her with a story the referring physician reported that he thought the patient told him of her having had a premarital pregnancy and abortion. The patient indignantly denied this with such vehemence and sincerity that her shaken therapist, after some reconsideration, told the patient the source of the information and freely admitted he could be entirely incorrect. The patient then, possibly getting the idea that sexual confessions were what the therapist desired, told of a very upsetting rape attempt by three Russian soldiers when she was fifteen. Shortly thereafter, Mrs R. made her first home visit and on her return somewhat agitatedly described her fear of having intercourse with her husband. The therapist reassured her that it was entirely understandable she might not wish to resume sexual relations at this time and the patient's agitation abated. The therapist then attempted to get the patient into a discussion of problems Mrs R. had with her husband but was met with a stone wall of denial. Mrs R. then began to show clinical evidence of depression. The therapist interpreted her mood change as evidence of her fear of another pregnancy. The patient then told of a pre-marital love affair and with increasing disturbance in subsequent sessions, continued to talk of love affairs, real and fantasied. With this she spoke of feeling

immoral and became so upset she required transfer to a hall for disturbed patients. She now began to speak of the complaints which persisted throughout the remainder of her hospitalization: lack of appetite, sleeplessness, and a constantly reiterated conviction of being hopelessly ill. The therapist, regarded this clinical change as an indication the patient was attempting to avoid caring for her newborn son and that her depression was merely an attempt to obtain further pampering. The following interpretation was offered: 'You are acting like a very small child who would, indeed, like to be placed in a crib along with your son' and 'your I can't really means you won't'. To this was added a reminder that the baby would only be small once and Mrs R. was thereby missing her only opportunity to be with and care for him. The patient's subsequent increased desperation convinced the therapist that she really was seriously depressed and, deciding the patient was in a 'log jam', a course of eleven ECT's were administered 6 months after her admission. There was no appreciable effect from the ECT, the patient continuing to maintain her insistent statements of hopelessness and not long thereafter she began to complain of nerves all over her body which she touched everywhere. The therapist interpreted this additional symptom as an indication that 'perhaps you don't want to get well and go back to living with your husband'. The patient responded: 'If I had the right feeling, I would love my husband.' The therapist then shifted his interpretation of the new symptoms of 'nerves' to an indication that the patient was experiencing sexual sensations, possibly of a masturbatory nature. The patient vehemently denied this, became greatly agitated and actively suicidal. After a brief period of maximal protective care, her suicidal intent gave way to her chronic despondent statements of hopelessness. The therapist then decided to stop offering a counter-barrage of reassuring disagreement with these statements. At this time also the therapist discovered the details of an important bit of information, vaguely referred to in the initial history but not followed up, to the effect that the patient's mother had suffered a post-partum psychosis at the birth of the patient, was hospitalized in a mental hospital, and died there two years later of pneumonia. This information, of course, could have been so useful to the therapist in the beginning work of understanding this patient's intense need to deny her illness. Confronted now by the therapist armed with this revelation, the patient merely replied: 'That's right, that's my essence—being bad from my start.' Now, 10 months after admission, it was decided that there was once again a 'log jam' and that the patient had passive wishes for which she could not accept gratification without a forced regression and the patient received a course of fifty-two insulin comas. Again there was no appreciable improvement except the establishment of a relationship with a very quiet friendly administrative physician. Mrs R. met all references to her problems by a storm of protestations that her body was dead, her vital force drained out, etc., etc.—in fact she was in need, not of further treatment in the classical sense, but of 'untreating'—for the re-establishment of human interaction.

I should like at this point to reiterate that the therapist who treated this patient was then of equal competence with other residents of comparable experience and is now a highly respected, well-trained psychotherapist. Had he been less so, the situation might have been in some respects less damaging. The patient who, so to speak, draws a dud can more easily protect himself from having heightened expectations of health than he can when his therapist is both basically a sound human being and, in addition, offers such skill and sensitivity as Mrs R.'s therapist demonstrated in diagnosing her urinary infection, handling her concern about resuming sexual relations, and in other instances I have not reported. Furthermore, the interpretations themselves so ill advised in timing and mode of handling, may well have been quite accurate in concept since as Freud (1905) states: 'A reproach which misses the mark gives no lasting offense.'

Before considering further the iatrogenic causes, I should like to attempt to clarify what factors in the patients might make them prone to this type of reaction. Of the quite varied group of patients grouped under the heading of people having schizophrenic reactions, we can eliminate large numbers who are not likely to be affected in quite the manner I am describing. The very chronically regressed highly disorganized patients are not apt to establish with a therapist the kind of relationship on a verbal level that would make them sufficiently vulnerable. Furthermore, the type of borderline patients described so graphically by Main (1957) in his paper 'The ailment', while similar in their seeming reliance on verbal contacts and in their almost hungrily seeking of narcissistically wounding situations, are different in that their transference reactions are split up among several people in the hospital environment. They are the patients who involve personnel at all levels into an externalized form of their inner conflicts, spreading disharmony among all. Mrs R., and many patients like her, do not become 'celebrated cases'. At the opposite end of the spectrum there are, I believe, patients who in spite of having sustained a psychotic break retain a sufficient reservoir of basically sound object relations that they can, after the acute episode is past, seek, stimulate, and utilize the human warmth in the environment, whether it comes from the charwoman, fellow patients, the nurse, or the psychiatrist. These fortunate people can generally bring out the best in us and even when they get the worst can be flexible in their handling of it. The less fortunate patients in the group with Mrs R. are, therefore, people who are able to establish a relationship with the therapist, and are sufficiently able to discern reality to seize upon the positive aspects of the interplay with the therapist. They are apt, however, to expect of the therapist a continuous flow of sensitive handling and of themselves a continuous flow of responsive improvement. They are apt also to be exceedingly impatient to receive demonstrations of the therapist's omnipotence and to give demonstrations of their wellness. Thus, they make initially rapid 'improvements' based on denial of their illness and seem to have a strong positive transference based on denial of their therapist's limitations. Obviously this is a highly vulnerable, unstable state of affairs requiring much tact and patience. Each breakdown in the relationship leads to an abrupt fall in the patient's hopeful expectations, loss of the 'halo' of clinical improvement, and a demand for a rapid restoration of the previous state. The patients calls on the therapist are likely to increase in stridency, while he also tries to please the therapist by producing more material—regardless of the painfulness of the content. Painful loss of high hopes, painful loss of praise for improving, and painful outpouring of material combine to activate in the patients whatever sado-masochistic pattern has been their wont. This pattern varies from patient to patient but generally at this point all interpretations are experienced as a narcissistic mortification and the resultant suffering tends to fixate the patient in a negative transference. Once this happens, I believe a change occurs in the patient's response to words. In their pre-psychotic personality, these patients are often quite verbal people, who have depended on words and intellectual functioning to gain a precarious mastery over their drives. When they regress, words seem to them magically endowed both as weapons and as shields. Mrs R.'s angry protestations of hopelessness were meant to wound her therapist and at the same time to serve as a protective ritual chant, anticipating and warding off further hurt from the therapist's words, which the patient regarded as similarly endowed with magic.

Let us return now to the factors that may be responsible for the therapist's errors. I believe there are three closely interrelated causes: (a) Inexperience in understanding the dynamics of the schizophrenic illness; (b) the misuse of models; and (c) counter transference problems.

Strange as it may seem, I have found over and over again that inexperienced hospital

residents fail to fully appreciate how severely sick schizophrenic patients really are. This is especially true if ·the patients are capable of mobilizing a defensive front using neurotic mechanisms. The resident is often impatient to reveal to the patient the dynamics of his illness, without regard for the desperate inadequacy of the patient's means of holding any integrated position at all. Furthermore, the inexperienced resident is very likely to regard the breakthrough of sexual material and confessions of all sorts as useful material to be encouraged, rather than as evidence of failing defenses in the partially re-integrated patient, and therefore to be discouraged at that time and postponed for working out considerably later.

I feel that some of the residents' difficulties result from their misunderstanding and misuse of the two models that carry for them the greatest prestige, the devoted, skilled therapist in hospital practice and the psychoanalyst. The caricature of the psychoanalyst as the inhumanly stone faced rigidly silent mirror, interested only in sex, is too well known to require further comment. For the skilled hospital therapist, who with careful sensitivity can approach patients with a reassuring frank directness free of social hypocrisy and cant, the caricature is the bludgeoning insulter, interested only in hostility. Caught up by his own unsureness, the inexperienced resident can easily identify with the caricatures noted above, and be silent when he might be humanly responsive, and inadvertently insulting when he might be tactful.

So much has been written about countertransference feelings of therapists working with schizophrenic patients that I wish only to stress in this context how difficult it sometimes is for all of us to accept that the needs of the sick person require very simple primary care and patience over often extended periods of time. It is the inexperienced therapist's failure to recognize the value of such treatment that lead him unconsciously to deny not only the length of the usual recovery period from a psychotic illness but also the partial character of the return of normal ego functioning.

Given the situation we have described with Mrs R., what is meant by untreating? Put most simply, untreating means finding some way of spending time with the patient in which both the therapist and particularly the patient can actively share and communicate. Because of the stalemate that has resulted, the use of the usual psychotherapy situation must be replaced by an informal means of being together. This means must develop out of a natural interest of both people and must allow the patient to feel a part of what he regards as his normal healthy personality is both involved and appreciated. To continue the example of Mrs R., the therapist who took over at the point I stopped the narrative, worked out by trial and error a way of establishing a relationship that helped Mrs R. to become less regressed and, although neither of them would by tacit agreement ever mention it, more hopeful. First, Mrs R. and her therapist agreed that little could be had in the way of creature comforts on the disturbed hall and that the active halls were all ' too onward and upward to health' in orientation, and besides a reminder of her failures. Then, after several testing visits, she willingly accepted transfer to a pleasant closed hall of mostly chronic patients. The new therapist spent about the same total amount of time with her as he would with any active patient. However, he found that more than usual flexibility of the length of any single contact—shorter or longer as his sensitivity would indicate— helped avoid excessive tension arousal. In addition the contacts were always in a setting, on the hall and off, not standardly used for therapy talks. Chinese checkers, and other sedentary games at first proved to be the most useful vehicles for sharing. Later, in spite of her persistent loss of 'vital force', ping-pong and walks were added. However, the main interaction for months consisted of the patient's persistent efforts to test the therapist by attempts at trapping him into being one of the two caricatures of a psychiatrist noted

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above; and his efforts to elude this manoeuvre. Mrs R. would launch into one of her varied protestations of bodily disintegration to which the therapist might reply by gently referring her back to the checkers game. Or she would suddenly grow reflective and describe some bit of her past history which would in other circumstances elicit his therapeutic interest into her feelings, etc., but to which he would now reply, as soon as he saw any evidence of her tension mounting by shifting to a related but neutral area such as the geography of that area of Germany or the difference between the gymnasium system and the American high school, etc. At all times, it was again tacitly understood that the therapist was listening and remembering the many important hints about herself she was throwing out in this way. One vehicle of communication that rapidly developed was a shared predilection for ironic humour. This was particularly useful at times of parting. These were for Mrs R. times of particular painfulness and rising tension. The dialogue at these times started with, 'I'll see you tomorrow', 'I'll be dead by tomorrow', 'Well, if that's so, I guess I won't see you tomorrow', and evolved into a discussion of the possible funeral home she might be sought at, the variety of caskets she might prefer, and so on. This conversation, of course, sounds ghoulish; but with this patient, it fulfilled the criterion of untreating in that it gave her an opportunity to share actively and communicate through the use of a part of what she regarded as her healthy personality—a tendency to treat serious matters with wry and sardonic humour. In addition, the flexible time arrangements allowed these interchanges to *feel* friendly and unhurried.

I am sure it is obvious from this brief description that there is nothing really novel about the methods involved—nor, of course, is there anything unique about employing informal or non-verbal techniques in the therapy of schizophrenic patients. Bleuler (1950) speaks of a startle technique of suddenly inviting a chronic patient to a party, Sechehaye (1951) used apples and dolls as symbolic means of communication and 'realization', Federn (1952) speaks of courting positive transference by hospitality, sweets and a female helper. The basic tenets of my approach owes much to the therapeutic recommendations of Hill (1955). The conclusions I have attempted to lead up to are twofold—a general one and a specific one. First, that I believe that therapeutic crises such as I have described are less apt to occur if the early therapy of hospitalized schizophrenic patients is conducted in an atmosphere of informality of place and time, etc., since the human, non-verbal elements of communication are at these times the crucial factors in re-establishing good interpersonal relations and further, that content emphasis on the here and now and the non-sexual avoids emphasis on narcissistically wounding and disorganizing interchanges. Secondly, I believe that there are specific clinical situations when the misuse of interpretive approaches call for the application of these general principles as cornerstones in the evolution of a therapeutic plan specifically designed to undo the patient's distrust and regression.

Two more brief examples may further clarify each of these points. A young woman, very suspicious of psychiatrists, primarily because of the destructive influence on her family of her mother's misquotes from her treatment, came to the hospital after a suicide attempt. As far as she was concerned, she loved only her dog, and had no use for people, especially psychiatrists, whom she regarded as the lowest form of the species. An approach of 'let's discuss your problems' sent her into tantrums of denial and withdrawal. Seeing her on the hospital grounds allowed for time spent together in a hostile truce. One day she noted the approach of the senior psychiatrist's big boxer with whom she had been slowly making friends. She called him several times, he started toward her, and to her absolute astonishment he sniffed at her and then came over happily to be ruffed up by the despised therapist, who was an old wrestling partner of the dog's. Subsequently, this girl allowed

herself in the presence of the now less despised psychiatrist to cry and sob and be comforted, again with the tacit agreement of no words or explanations. After this further thawing, verbal communication was established.

The second example is of a patient caught up as Mrs R. in intense loss of self esteem, chaotic self derogation, and the turning of every interpretation into sadomasochistic assault and counter assault. In a casual exchange this patient mentioned something about Tanglewood, Massachusetts, which led to a mention of its annual Music Festival, which then led to the discovery of a hitherto unknown interest of his in classical music. A spontaneous sharing of opinions on this subject occurred, and for a period of fifteen minutes, the patient completely dropped his outpourings about the slow death of his brain cells and the torture of the tub bath he was in. This common bond was renewed with interest several times thereafter and years later this patient reminded the therapist of this incident as the one thing that recalled to him the side of himself that he considered worth while.

In conclusion, I wish to state that I do not at all mean to imply that I am depreciating the value of investigative techniques in the therapy of schizophrenic patients when they are possible. On the contrary, I consiper them to be the cornerstone of truly ego maturational approaches, whether the patients be psycho-neurotic or have suffered a psychotic illness. However, with a psycho-neurotic patient, one cannot do an analysis unless the patient and the analyst have been able to achieve an analytic situation as defined by Stone (1961) and others. Similarly, I believe with a schizo-phrenic patient one cannot do investigative work unless the patient and the therapist have been able to achieve a working relationship of mutual trust. To persist in offering interpreta-tions when the basic therapeutic relationship is not established or has disintegrated is like feeding a person empty egg shells because he is vomitting eggs. The untreatment techniques are really only therapeutic approaches which state implicitly to the patient that for the time being we cannot get to do the kind of work that will probably eventually be necessary because it was attempted with so many errors in basic understanding of your needs that first we have to work to restore your faith that you and another human being, who *is* a trained therapist, can understand your basic needs. We must do this slowly and patiently without allowing either of us to exploit the other by unrealistic demands and within a context that at all times maintains a therapeutic objective regardless of the formal means employed.

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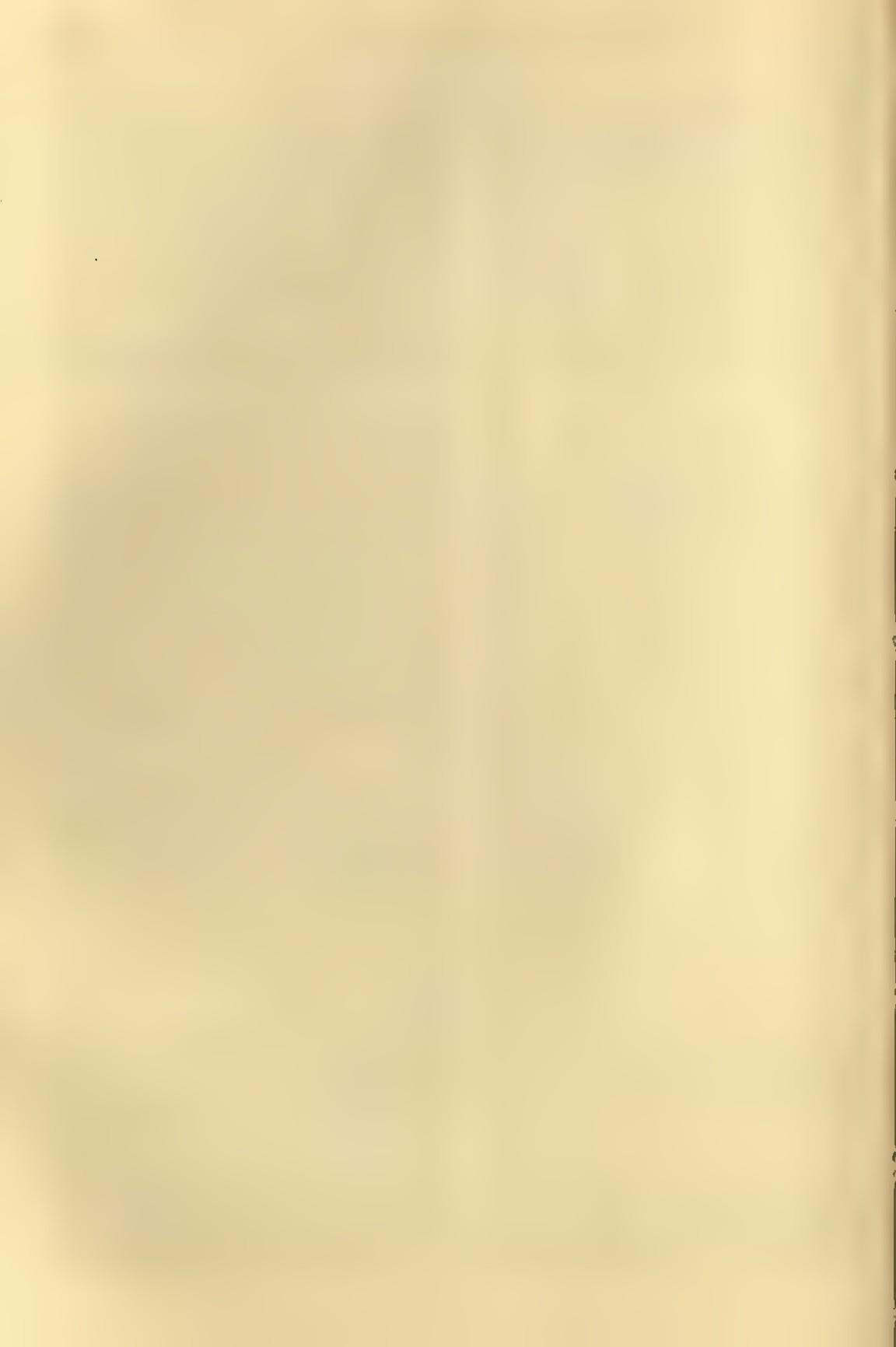
Modern physics and psychology

By THOMAS PICK*

Introduction

In accordance with the bias of this paper I should like to clarify my relationship to it from the outset. I am not a physicist, neither am I a logician; I am a clinical psychologist troubled by some of the epistemological implications of my day-to-day operations. Thus, this paper will be unsophisticated as it is motivated by my bewilderment over some of the things I do daily.

In interviewing of any kind we ask the subject or client or patient questions (directly or indirectly, directively or non-directively) and subject him to the impact of our person. To the extent to which we do this, we are changing the very state of affairs we are trying to assess. To go one step further, unless we can assess the effect of this interaction on the process in question, our assessment-on-the-basis-of-interaction will be inaccurate within unknown parameters. Thus, the most important problem becomes how to allow for the effects of interaction on the process of assessment.

The parallel to this situation in nuclear physics is that the process of mensuration changes the micro-processes measured. From this point of view, by the way, field observation becomes a more respectable tool in human psychology than experiment, testing, or interviewing.

However, there are other problems in interviewing.

The clinician, in so far as he uses intuition and rehearsal (Dollard & Miller, 1950) or 'understanding', stands in a subject-to-subject relationship to his subject. Thus, one of the difficulties, apart from standardization, is that

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the measuring unit is of the same order of magnitude as that which is measured; this is another parallel to nuclear physics.

These were the similarities which induced me initially to become concerned with the problems this paper poses.

Science and metaphysics

It is often said that modern physics lends support to a non-materialistic, even to an idealistic philosophy. Although this is grossly unwarranted as an inference, it makes sense psychologically. While in the nineteenth century the optimistic view prevailed that the 'real world' was, in principle at least, amenable to description and explanation, it now seems likely that this is not the case. However, the law of 'Praegnanz' operates in all of us: we all find closed systems comforting to varying extents. As a consequence, our threshold for unwarranted metaphysical extrapolations from the limits of our knowledge is very low indeed. Instead of the old gods of materialism that seemed to have failed we may tend to reinstate the no less ancient ones of idealism, introducing them through the gaps on the frontiers of our knowledge. There is reason to believe that some of these gaps may be irreducible in principle (Heim, 1953).

Others amongst us may subscribe to the 'eleatic principle' (Metzger, 1954, p. 8) according to which 'logical reasoning is the final arbiter over existence versus non-existence. Nothing must be accepted as real merely by virtue of its immediately experienced presence, everything is required to have a reason first. Only what is explicable is real. Whatever cannot be expressed in an unambiguous proposition is non-existent. (It is not at all considered that the contradiction may lie in semantic shortcomings.)' (This writer's

translation from the original German.) Examples of this attitude appear when the unconscious is dismissed as a 'contradiction in terms' or if one refuses concerning oneself with the unconscious as lying outside the field of psychology.

INDETERMINACY IN NUCLEAR PHYSICS

In the following we shall look into an age-old epistemological and ontological problem brought into focus again by modern physics. It has direct relevance for psychology.

The problem is that of determinacy. In the frame of reference of determinism (Heim, 1953, p. 24) 'the course of world events is absolutely established because it is subject to the universally valid law of causality, according to which one event follows necessarily from preceding events'.

Let us now consider the problem of determinism in physical science from the point of view of the breach brought about by Heisenberg's Uncertainty Principle.

Bronowski wrote (1951, pp. 67–68):

Heisenberg showed that every description of nature contains some essential and irremovable uncertainty. For example, the more accurately we try to measure the position of a fundamental particle, of an electron say, the less certain will we be of its speed. The more accurately we try to estimate its speed, the more uncertain will we be of its precise position. Therefore, we can never predict the future of the particle with complete certainty; because as a matter of fact we cannot be completely certain of its present....If we want to predict its future we must allow for an error term. We may have what metaphysical prejudices we choose...but the physical fact about these small scale events is beyond dispute. Their future cannot be foretold with complete assurance by anyone observing them in the present.'*

* In this context the objection was raised (O'Neil, 1962) that the ontological problem of determinism must not be confused with the epistemological problem of the certainty of knowledge. The conceptual distinction is certainly worth making but the fact remains that from the

Heim said (1953, p. 132):

As Niels Bohr has always insisted, the point is not that the act of observing interferes with a situation in the action as it is in itself, but rather that *the physical interaction of observer and object is generally and from the outset a necessary condition of knowledge.* [My italics.] 'From this general principle, which obtains also in classical physics, the quantum-mechanical uncertainty follows because of the additional circumstance which appears in the 'dualism experiments' and which can be formulated as follows: the kind of interaction between observer and object which is necessary if certain properties of the object (e.g. its position) are to be displayed, cannot take place simultaneously with the interaction which is necessary if certain other properties (e.g. its momentum) are to be displayed.'

This leads to (p. 132):

the quantum-mechanical uncertainty of such magnitudes as can only be determined by the kind of interaction which has been ruled out..., Following Bohr, we call this the 'denial of objectifiability in atomic events'.

Heim elaborated further (1953, p. 220):

The frontier of which we are now aware is an absolute frontier, imposed by the nature of the case. It arises from the fact that the whole of exact natural research, with all its appropriate methods, lies within the limits of a particular space, within which all being and happening must be ordered and beyond which we cannot see and shall not be able to see....

We can (*op. cit.* pp. 49–50):

...compare the new uncertainty of quantum mechanics with a somewhat older one that is involved in the kinetic theory of gases. The idea of a gas being composed of very small particles whose bulk occupies only a very small portion of

point of view of the operations needed to approach ontological or epistemological problems the two are hopelessly and irreducibly confounded. To put it in different terms, the only way to prove that a problem arises on the ontological rather than on the epistemological level is to solve the epistemological counterpart of the problem first. Thus, the distinction is worth keeping in mind but it does not affect the argument.

the total space is a product of the first half of the nineteenth century. The picture of a gas as a swarm of fast-moving particles has inherent in it a statistical view of the whole scene. No one attempts to trace the course of a single molecule flying about and bouncing off the walls of a container or off other molecules, but it is possible to treat mathematically a large number of such particles.

Now, most of the interpreters of modern quantum mechanics sharply differentiate between the uncertainty in regard to any single particle in a gas, according to the kinetic theory, and the uncertainty as to the position of a binding electron in a molecule.... Until quantum phenomena intruded themselves on physicists and quantum mechanics developed, scientists were convinced that *in principle* (my italics) the motion of every particle could be calculated in advance. Now they are convinced that this is true only within certain limits defined by a mathematical equation.

INDETERMINACY IN THE BEHAVIOURAL SCIENCES

In the behavioural sciences the problem of determinacy may be worth raising at two levels:

First, as regards the neurophysiological substratum of behaviour. The sort of problem one may consider here would be Eccles's suggestion (quoted by Friedman, 1960) that at a decisive point in neuronal pathways, psychological results may be determined by structures small enough to 'come under' the Heisenberg Principle, in other words, psychological states may represent or correspond to random firing of neurons.

Secondly, it may be raised at the level of interaction in psychological mensuration and interviewing. In this context, two problems must be kept clearly apart conceptually. These are the problem of mensuration by means of an objective test as against the problem of the clinician as a measuring instrument (what Payne (1957) calls the clinician as an oracle).

In the first case, one only has to consider changes brought about in the subject under the impact of mensuration. In the second case, however, when the clinician is the measuring instrument, the problem is extended. We shall return to this problem later.

It may be helpful to consider lack of observed determination as arising in one of the following ways:

Prior to measurement

(1) Dependent on the level of analysis. Example: on a sociological level of analysis events on a psychological level are 'indeterminate'. Thus, for an area with known ecological characteristics and data from past years we may be able to predict the number of people liable to be certified over a certain period of time and we can specify the margin for error. However, at this level of analysis no predictions can be made about individual members of the population. This type of indeterminacy is not necessarily irreducible. The situation can be said to be analogous to indeterminacy as regards the single molecule in the frame of reference of the kinetic theory of gases.

(2) Dependent on the effect of variables not included in the system. Example: the effect of fatigue and motivational factors on performance in cognitive tests.

During measurement

(3) Dependent on measurement. (*a*) Dependent on unit of measurement. We cannot measure things smaller than the unit of measurement. Example: a score of zero on a test. This type of indeterminacy only becomes irreducible if the size of the unit of measurement reached its minimum.

(*b*) Dependent on mode of measurement. This is the type of indeterminacy analogous to Heisenberg's Uncertainty Principle. Example: definition of the test situation as a particularly anxiety creating school situation on the part of a child may result in the test score reflecting anxiety level rather than being a measure of cognitive abilities.

INDETERMINACY IN
CLINICAL PSYCHOLOGY

Popper writes (1959, pp. 209–10): 'I call a probability statement "formally singular" when it ascribes a probability to a single occurrence, or to a single element of a certain class of occurrences; for example, "the probability of throwing five with the next throw of this die is 1/6" or "the probability of throwing five with any single throw (of this die) is 1/6", is a "formally singular" probability statement.'

As *most, if not all, scientific statements in applied clinical psychology are of the formally singular kind* problems posed by quantum theory are highly relevant to that field. In the following, let us work from the least rigorous mode of interaction (interview) to the most rigorous (test).

The point of view shall be an operational one without making inferences about the nature of reality. Instead, I hope to be in a position to show that there is some analogy between difficulties encountered in nuclear physics and in psychology, especially in clinical psychology. I shall try to demonstrate that just as in nuclear physics the interaction or process in the act of measurement imposes limitations on the content and precision of the result, the act of observation and/or measurement imposes corresponding limitations on psychological data.

(a) Indeterminacy in interviewing

Let us assume that I am interviewing a child. I ask him a simple question: 'How do you like school?' He answers: 'I like it.' Assuming that the noise-level was low, the child's voice reasonably loud and the interviewer was neither deluded nor deaf and was familiar with the English language he would have perceived the proposition without distortion. The problem starts if one poses the question: 'What does this statement mean?' First, of course, it may mean that the child really likes school. Secondly, it may mean that the child feels he ought to like school.

Thirdly, the child may be conditioned to say the 'right thing', i.e. say what is socially most acceptable. Fourthly, the child may want to please me. And so on, *ad infinitum*: I have only mentioned the meanings I have found clinically worth following up.

In the foregoing a model of attitude-in-personality has been assumed. We could represent it diagrammatically thus:
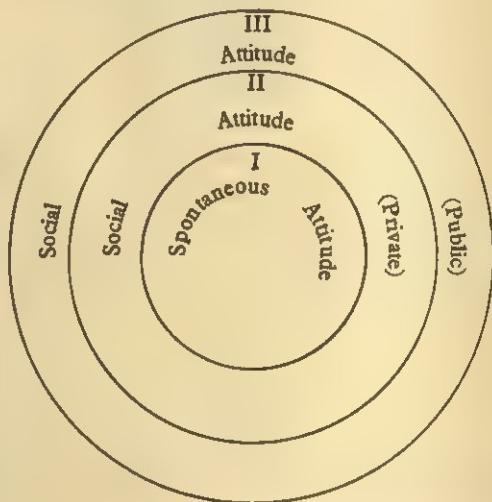
(For the logician: this is not meant as a class diagram and it is acknowledged that if one applies the scheme consistently one may be faced with an infinite regress.)

The first meaning mentioned, that the child really liked school, is on the 'spontaneous attitude' level, represented by the innermost circle (I). The second one, that the child felt he ought to like school, is on the social attitude (private) level, represented by the middle ring (II). The third one, the child being conditioned to say the 'right thing', is at the level of social attitude (public), represented by the outer ring (III). The fourth meaning, that the child wanted to please me, may be independent of the variables on the diagram.

What is, then, the parallel to indeterminacy in nuclear physics? After all, we have other ways of showing it to be likely that the response stemmed from level x and not from y or z. The situation in nuclear physics is quite analogous, my nuclear physicist friends as-

sured me. Indeterminacy exists only in relation to the single act of mensuration. At time t_1 we may measure the position of a particle with maximum accuracy, and at t_2 we may measure its velocity with maximum accuracy. I hope to show that the situation is analogous in clinical psychology. To get back to our example of the child's attitude to school, if we phrase the question differently, such as 'school is a horrid place, isn't it?', we maximize the likelihood of a level I response—or of a response determined by our fourth meaning 'I want to please you'.... If, on the other hand, the question is put in the form 'you like school, don't you?' a conforming level II or level III response is favoured by most. Thus, the area of minimum and maximum determinacy can be varied by manipulating the demand characteristics of the situation. To recapitulate, then, in any one response there will be indeterminacy (type (3) (b), p. 321) in relation to the levels 'not tapped' by the demand characteristics of the situation. In a child's affirmative response to 'school is a horrid place, isn't it?', there will be mainly determinacy (variance contributed by) level I, and indeterminacy (little or no variance contributed by) levels II and III. If we want to plot the child's 'attitude curve' during the interview on all those levels, we can influence the various levels' 'determinacy' by manipulating the demand characteristics. We can thus obtain a fairly complete record on all three levels.

(b) Indeterminacy in testing

In testing, too, we measure interaction between subject and task, or between subject, task, and tester. The rationale seems to be that as the tasks and behaviour of the tester are standard, both inter- and intra-subject variance will yield information about the subject. Assuming adequate sampling of relevant items of behaviour and reasonable consistency in that behaviour the above rationale seems unassailable.

More precisely, adopting a Spearmanian definition of intelligence, let us assume that it

has been found that $x\%$ of the variance of a particular item is due to g; it will then be assumed that in a tested individual A $x\%$ of the variance of that item will be attributable to g. With a large pool of items confidence will grow that the g-loading for the individual approximates that for the population. Strictly speaking, however, the more atypical the individual the greater the likelihood that his g-loading for the pool of items will differ markedly from that of the population. This is a general statement subsuming such specific statements as 'the subject is under-performing due to neurotic inhibitions'. The subject's response is a function not only of whether he has the response-potential stored within him, so to speak, but also of his perception of, and attitude to, test, test item, and tester. Thus, from the clinician's point of view, there is always an element of indeterminacy in the subject's responses in terms of their g-loading, and, more generally, their meaning. This indeterminacy will be the greater the more atypical the subject is in relation to the standardization population.

This, however, does not necessarily mean that the measure will be less reliable for the atypical individual. It follows logically that, for example, consistently very low level of motivation makes for high stability of performance on retesting. In other words, the measure will have high reliability but lowl validity qua intellectual assessment.

To consider intelligence testing further: let I.Q. mean what it normally does on a test T, let Ct stand for cognitive abilities relevant for solving the items of test T, and let At stand for available achievement motivation in so far as it affects performance on test T. It is obvious that the following functional relationship then holds, I.Q. $= (f)CtAt$. However, the variable for which we seek a numerical value here is Ct. To the extent, then, that the testee deviates from the population norm on At, his I.Q. will be co-determined by At to that extent, and the more so the more the individual deviates from the population norm on At. One of the attributes of the good tester is to

minimize the effects of variable *At* by increasing the motivation of the seemingly under-motivated and by calming the over-anxious.

However, it is obvious that we cannot measure both *Ct* and *At* accurately in the same operation. Just as in nuclear physics the position *and* the velocity of a particle cannot be determined simultaneously with accuracy, so we cannot measure cognitive ability and achievement motivation with maximum precision simultaneously. Thus, for a given population we can design a test to give us maximum discrimination either for the dimension of cognitive abilities or for that of achievement motivation. On the other hand, for the individual testee the variance contributed by the other variable may be considerable. In any case, the operations maximizing accuracy for one variable minimize it for the other at the same time. However, this analogy must not be carried too far as the problem for physics arises from having to stop the particle to determine its position (thus changing its velocity), whereas in psychology it is a matter of trying to disentangle the confounded variables of cognitive ability and achievement motivation.

(c) Indeterminacy in testing and interviewing compared

The nature of this indeterminacy, however, seems different in testing from the one we discussed with interviewing. Whereas the locus of the indeterminacy could be manipulated there by varying the demand characteristics of the situation, it is well beyond our control here. With the very atypical individual, we simply may not know what we are measuring when testing him. This is where the Maudsley school (Payne, 1957) has a great deal to offer. Also (Lafitte, 1957, p. 16) '...in handling objective measurements, the experimenter's reference to himself is limited, but is none the less inevitable if he is to understand what he is doing, which means understanding a problem presented in someone else's behaviour.' (Example: a 'factor', in so far as it

may be given meaning over and above actuarial prediction.)

This argument could be extended. In another paper (Pick, 1956) I made a distinction between extrapolating predictions from tests and dynamic interpretations. In the latter, test signs or scores are sought which are indicative of underlying psychological processes. Take the Rorschach interpretation of a score, for instance. Let us assume that the interpretation has been established empirically. This must have occurred in relation to a finite standardization population. The rest of the argument is the same as that for the g-loadings. The more atypical an individual is the less can it be assumed that the interpretation holds for him individually. Thus, it follows that dynamic interpretations in so far as they rest on findings from a population are the more uncertain the more atypical the subject of the interpretation is in relation to that population. For extrapolating or merely empirical predictions the arguments hold *a fortiori*.

With interviewing, whether diagnostic or therapeutic, the same holds. Lafitte writes (1957, p. 16):

...in handling open interview material, the experimenter may refer the person's behaviour directly to his own experience in order to infer intentions. This is a simple analogical judgement: 'What would I mean if I said that.' It can be referred to past or present experience or to imaginary experience. It is a common, if only an implicit, component of the practical judgements of daily life in all new personal situations (which means practically all situations) and it is probably a component of most of the psychologist's complex judgements of persons.

This is a process Dollard & Miller (1950) called 'rehearsal' in psychotherapy. It is a process, a technique, deliberately used by the psychotherapist. Its aim is to reproduce an approximation to a segment of the thought process of the patient in the here-and-now situation. The object of rehearsal is, by the way, to identify 'missing links' in the client's chain of thoughts. For instance, a child may

talk about numerous instances of a sibling being preferred to him by mother. Then, he seemingly changes the subject and repeatedly says, with some emotion, how at times he hates his teacher, Miss L. On rehearsal, I felt that in this instance the missing link was teacher = mother. Rehearsal is, or at least should be, the basis for interpretation. However, there is a major and basic difficulty here: there must be a sufficient similarity between the respective psychological processes of the two people in the therapeutic relationship, they must be on the same wavelength to a large enough extent for relatively undistorted communication to occur. There can be two reasons for distortion here. First, the thought processes may be too dissimilar. This is a categorical variable independent on interaction. The second reason for distortion could be a poor relationship. Let us leave the second reason aside for now, and concentrate on the first. The thought processes may be too dissimilar either because the therapist is atypical in his thought processes on rehearsal, or because the patient is, or because both are, in different directions. Let us take the ideal case of a therapist who is flexible and who has had a great deal of experience (including his reading) with atypical patients' atypical thought processes. He will be able to 're-hearse' a very much wider range of thought content than less flexible people with less experience. However, even he is likely to experience more difficulty more frequently with the atypical; the more atypical an individual or, more precisely, the more an individual deviates from the modal functioning of the therapist, the greater the difficulty for rehearsal. This may be one of several reasons for the relative inaccessibility to psychotherapy of the schizophrenic adult and the autistic child.

In terms of interaction between clinician and patient, let us consider a schizoid psychologist's attempt to 'understand' a hysteroid client's experience. I shall quote Lafitte (1957, p. 21): '...if he often enough hears about and sees the hysteroid's habit of re-jecting tasks with indifference or contempt as soon as they become difficult, he will be better able to imagine himself doing this even though his own work habits are tenacious to the point of rigidity. None the less, he does not have the...hysteroid's experience.... The most he can do is to imagine the experience: and this is obviously a very limited basis for making analogical interpretations....'

It seems, then, that in relation to the observer or therapist, in so far as he is depending on 'rehearsal' for knowledge about the individual patient, certain aspects of the latter's behaviour remain 'indeterminate' (type (3)(b), p. 321).

COMPARISON BETWEEN DATA-GATHERING IN NUCLEAR PHYSICS AND IN CLINICAL PSYCHOLOGY

What are, then, the similarities in the difficulties nuclear physicists experience in their observations and acts of measurement with those clinical psychologists encounter, and what are the differences?

(1) *Similarities*

(*a*) In both cases the act of observation and/or measurement materially changes that which is under observation. This holds for nearly all kinds of psychological measurement and observation.

(*b*) Measuring unit and that which is being measured are often of the same, or nearly the same, order of magnitude, thus imposing insuperable limitations on the accuracy of measurement. This holds for 'subjective' clinical assessments in the main.

(2) *Differences*

(a) Measurements in nuclear physics have an absolute magnitude (more precisely, I mean constant magnitude within a given space-cum-time) and there is a zero point on the scale of measurement. Neither holds for psychological measurements, excepting the limiting case of physiological measures such as the psychogalvanic skin resistance being used as a quasi-psychological measure.

(*b*) Unlike clinical interviewers, trained observers in physics are interchangeable with no appreciable difference in result.

(*c*) The interaction in the act of measurement occurs, at least with individual testing and interviewing, directly between observer and observed, whereas in nuclear physics it occurs between a minute measuring unit or its prerequisite (such as light) and that which is being measured.

(*d*) Psychological data, by virtue of their being macroscopic, are potentially reducible to other, more microscopic measurements (Koch, 1959, p. 300).

CONCLUSION

The suggested conclusion from all this is, generally speaking, that the utmost caution is in order in the evaluation of individual findings, and clinical findings *par excellence*. Due to factors making for indeterminacy as discussed above generalizations beyond the situation of observation are uncertain and, what is more, for clinical assessments the parameters of uncertainty are unknown, too.

However, awareness of the source of indeterminacy also makes it possible to minimize its effects by manipulating the situation. A large residue of the problem, however, must by necessity always remain. Whatever we do, some indeterminacy of unknown parameters will stay with us in any and all clinical situations.

SUMMARY

In this paper parallels were sought between nuclear physics and psychology, especially clinical psychology. A clarification of the role of indeterminacy in the two sciences was regarded as the main aim, with particular reference to similarities, and also to differences.

Indeterminacy in both data-collecting and mensuration was regarded as the main similarity in that in both sciences the very act of observation or of mensuration changes its object, the thing it attempts to observe or to measure. It was shown that some of the indeterminacy was irreducible. However, it was also demonstrated that indeterminacy could be reduced by manipulating the mode of data collection.

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Experience with a group of chronic psychotics*

By SALOMÓN RESNIK†

Group therapy can become a useful tool for exploring tendencies and tensions in interpersonal relationships, and can also be a means of investigating different aspects of communication in that particular setting. I shall discuss in this paper an experience with a group of six male chronic psychotic patients in a large mental hospital.‡ There was also an observer, a colleague on the staff of the hospital, who sat beside me during the sessions.

The group lasted several years and was an attempt on my part to deal with long-term chronic patients who were particularly difficult to approach verbally. I will show through the development of one session some of the characteristics of the specific language used in the treatment process. I found it particularly important to understand the specificity of the group language and the levels of communication, and also to learn the way to give interpretations which were meaningful to them.

The particular session which I am going to discuss started a little later than usual, and one of the patients said 'Good evening', although in fact the group was being held in the morning. Following that, another member of the group approached me with a piece of paper with writing on it which he appeared to want me to read. A third patient, whom I will call Mr B, mumbled (his mouth contracted)

something which was difficult to catch, though I could understand that he was telling us something. I caught a few words, such as, 'brother...abandoned...dear'. At the same time he made gestures with his hands indicating empty-handedness and loneliness.

I interpreted to the group that some of them had remarked upon our lateness by saying 'Good evening' and that that had increased the impatience of the group; that each patient in a different way was trying to get attention and understanding: one of them by mumbling and gestures, another by writing, and the others by their attitude of tense expectancy.

After a few minutes a patient remarked on the fact that Mr B had mumbled something in a confused and indistinct way, and said that he could make himself understood better by singing, as he did sometimes, and added that this must be because when he sings he feels spontaneous and free to express his feelings, but when he talked his words were 'empty and without soul....' I interpreted that when Mr B was able to sing he was then putting feeling into his language—'soul into his words'—but when he speaks his words are without feelings—'empty' or perhaps impregnated with resentment towards the 'dear brother' whom for a moment he thought I was and by whom he felt abandoned (by my coming late).

As we know, words in a psychotic patient have not always a symbolic meaning, that is, they are not abstractions of the primary object; but in animistic thinking words can become something material and concrete, just *things*. Hanna Segal, in her paper 'Notes on symbol formation' (1957) discusses in detail the process of symbolization, particularly in connexion with what she calls 'symbolic equation'.

In Mr B therefore, talking and expressing resentment at being left and not having his demands fulfilled, became something really dangerous to him—he was expelling words as concrete things. For that reason I regard his mumbling (with contracted mouth) as a non-verbal way of controlling his 'dangerous' words-things. On the other hand, words 'without soul' meant words empty of their violent contents. Singing was an attempt to transform feelings into something which is not harmful, into something creative, tending to recreate what is lost (attempt at sublimation).

At one point, Mr A, another member of the group, started to talk about 'patients who complain of pains and troubles in their bodies and go to doctors for injections...'. In presenting this hypochondriacal phase in the symptomatology I emphasize that besides the speaking language—the singing, the gestures, the writings—the group were able to express through the body anxieties and pains which were afflicting them. I attempted then to discover the fantasy underlying their hypochondriacal symptoms, in order to give the group insight into the defensive deflexion of mental anxiety on to the body.

The same patient, as he talked, was gripping an empty mug which he always brought to the session. Perceiving the underlying feeling of 'emptiness', for which the mug stood in the group, I said that not only Mr A, but all the others too, felt themselves to be 'empty mugs' who wanted to be filled. After a silence following this interpretation Mr A started to ask questions: 'How many people do you bring to life here?...' 'Can you cure people with cancer and syphilis?...' 'What germ produces cancer?...' Another patient talked about the 'death time' and Mr B started to sing *a sotto voce*, 'Brother...if the doctor could be mine...mine...mine...'. I interpreted what the members of the group felt about the illness affecting them. They identified it with something terrible, a 'cancer'. Besides showing their feeling of hopelessness they were asking to be cured and expressing

their fears and doubts about this. (I believe that in any psychotic, however chronic, there is a part of the ego which tries to co-operate and which wants to be helped.)

At that moment a patient who had not spoken till then and who tended to speak in an incoherent, metaphorical way, said: 'The salvation of cancer relieves the cancer of the soul.' These words expressed what we can call the specific underlying fantasy of the group illness, in which the mental illness is experienced as a 'cancer of the soul' which they were frightened to know but of which at the same time they wanted to understand the cause (the 'germ').

It was interesting to observe how the most regressed and deteriorated of the patients, whom they called the 'baby', expressed himself by movement and gesture, translating the most primitive feelings of the group (their earliest anxieties). At the beginning he was apparently listening and concentrating on what was going on. He looked like an adult. But as the session proceeded he became more and more like a small child, frightened, hiding himself in the crook of his arm. I regarded his behaviour as an index of the more primitive needs and anxieties of the group.

At one point two of the patients at the same time, one to me and one to the observer, demanded affection and help, one of them by saying: 'The piece of bread we want....' I felt that the way the patients approached us, the observer and me, was a sort of demand; and they spoke with such force and greed that I had a feeling they were two small babies who wanted to possess the mother and to suck her dry. I interpreted this in terms of the observer and me representing the mother of the group, part of the mother which they regarded as the whole mother, the two breasts which they demanded frantically.* Immediately after my remark, one of them, very excited and upset,

* Melanie Klein, in her paper, 'Early stages of the Oedipus Complex and of Superego Function' (1932) says in talking about the small child that when oral sadism increases during and after weaning certain 'oral-sadistic phantasies of a quite

said that my words were a nightmare falling suddenly upon the group. '. . . At this moment everything seems like a dream—a courageous one—which is exciting and upsetting and wakes up in a fright a group of people who were asleep.' I interpreted that my words were experienced by the group as a sudden nightmare which fell upon them and woke up suddenly what had been asleep perhaps for a long time in them.

After that, another patient, looking at the observer in the group, said; 'Once upon a time there was a she-wolf who fed two little children . . . .' And, looking straight at the observer's brown jacket, he described it as being made 'from a beautiful fantasy'. Now the wolf stood for the observer into whom they projected the image of a regained idealized mother (the 'beautiful fantasy') to whom they wanted to attach themselves. In this way they replaced the lost 'attacked' mother by an idealized one. The idealization was a defence.

After a while one of the patients expressed his greed and individual need by saying; 'Every child wants both breasts for himself . . . .' In this statement is implied also the underlying resentment at having to share the mother with other members of the group. My tendency to interpret here in terms of losing and regaining the object is in accord with my perception of the depressive anxieties* of the group. But in fact these anxieties are most of

definite character seeming to form a link between the oral-sucking and oral-biting stages, in which he gets possession of the contents of his mother's breast by sucking and scooping it out. This desire to suck and scoop out, first directed to her breast, soon extends to the inside of the body.' (From partial-object to whole-object.)

Karl Abraham (1924) draws attention to the vampire-like behaviour of some people and has explained it as being the effect of a regression from the oral-sadistic to the oral-sucking stage.

* Melanie Klein called depressive anxiety a state in which the child expresses feelings of sorrow and concern for the loved object, the fear of losing it, and the longing to regain it—pining for the object (1940, p. 316).

the time connected with paranoid feelings of resenting, hurting, and being persecuted by the object (externally and internally).

The group then tried, through speech, singing and mimicry, to bring to life, to recreate, and to restore the image of the beloved mother whom they both loved and hated. When I interpreted the different forms of expression of the different members of the group I gave attention to one of them who had not spoken till then and who looked very tense, angry and jealous. And as I looked at him he said that he was not interested in the people 'with cancer and syphilis' and he did not know why he was there in that hospital, and that he knew his wife was deceiving him and that everybody was accusing and mocking him. I interpreted that he felt that as I had not looked particularly at him, as I did now, that I did not care about him, that I was unfaithful to him, like his wife, and that now I was just playing with and mocking him, and that he was very cross about that. He replied, saying that nothing was wrong with him, that the other people in the group were crazy and that the nurses of the ward were abnormal and persecutors just like his wife and the other members of the group. I remarked then to the group that they had two ways of confronting the 'cancer of the soul': one was to perceive the illness of the group as belonging to them, as part of themselves, a very destructive part (cancer, syphilis); and on the other hand the group dramatized through this last patient an attempt to deny the existence of that feeling within them and to shift it to somewhere else as not belonging to them (to get rid through projection of the upsetting part of themselves, the 'cancer of the soul', the greed and jealousy). Both forms of conceiving and dealing with the concept of mental illness correspond respectively to depressive and paranoid anxieties: to be aware of the illness in the first place, and in the second place to project it somewhere else.†

† I use the concept of persecutory and depressive anxieties in Mrs Klein's sense; first of all, the persecutory anxieties related to sadistic phanta-

One of the aims of this paper was to emphasize the different forms of communication in a group. I would therefore like to make an additional remark about the meaning of the fluctuations in the group structure as it differed from one moment to the next, something which I regard as a sort of changing 'body-scheme' of the group. Also to emphasize the different roles played by the patients in the different situations. I described as being the most regressive the baby who did not speak and who only expressed himself by gestures. He placed himself in situations of anxiety next to the observer and me. And the most paranoid member of the group put himself the further away the more he stood for the paranoid feelings of the group.

CONCLUSION

I wanted to show in this paper the possibility of approaching a group of chronic psychotic patients and also to illustrate how sies in relation to the mother's breast (partial object), to the mother's body (total object); and secondly, depressive anxieties, which relate to the feeling of pining for the attacked object and subsequent feelings of guilt and need for reparation (1945, p. 339).

analytic technique and interpretation of transference can be introduced in a therapeutic group. In these particular patients with a certain deterioration in their capacity to think most of the phantasies are expressed at a non-verbal level or through a verbal expression with a pre-verbal meaning. I regard it as particularly useful in a group of very regressed patients to interpret more in terms of psychotic mechanisms of the ego, as described particularly by Melanie Klein in her paper 'Notes on some Schizoid Mechanisms' (1946). I believe that one of the roles of the therapist is to be a sort of translator or mediator between pre-verbal and verbal thinking. I also think that it is correct interpretation which stimulates in the members of the group the capacity to develop from concrete thinking to symbolic verbal expression. I wanted to emphasize also that an analytic approach and the understanding of early levels of development and primary anxieties are fundamental for dealing with such regressed patients. The task of the therapist in formulating interpretations is to be aware of his countertransference feelings; thus to be in touch with his own psychotic mechanisms and phantasies aroused by the transference 'psychosis'.

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Pathological identifications

A contribution to direct analysis

By ALBERT M. HONIG*

In all living matter, the process of identification exists. This is reason enough to believe that it is a basic procedure, perhaps innate. Its origin perhaps draws from the very nature of protoplasm itself (Tinbergen, 1951).

Many have said that man's compassion to man is therapeutic. It is only during this century (since Freud) that attempts have been made to define scientifically how this compassion operates in treatment. Identification is certainly the core of this therapeutic process. Within this paper, I will attempt to show why I think this is so. The tools of my therapy stem from that part of psychoanalysis named direct analysis. The patients referred to during the paper are mostly psychotic, although the treatment procedure has been adapted to neurotics as well.

The paper is divided into four sections. The first section is a review of the normal process of identification. In the second section there is a discussion of what I have termed pathological identifications. There is a description of, and a proposed theory for, the cause of pathological identifications. Section three is a series of clinical examples of pathological identifications, and section four is a review and final discussion.

NORMAL PROCESS OF IDENTIFICATION

An infant is born with needs. We call these needs instinctual and say they derive from the unconscious. The ability to meet the infant's needs, we define as maternal instinct. Freud (1923) states: 'In the primitive oral phase of the individual's existence, object-cathexis and identification are hardly distinguishable from each other.' When an object is cathected, it is

with the full emotional impact of the id. This eroticization, which is directed at first only to the breast, soon encompasses the total organism. The person cathected is of course the mother or her surrogate. Spitz (1950), Klein (1934), and others, have emphasized this point. According to Freud,* before identification can take place, the libido must be desexualized by a withdrawal from the object. It then becomes centred again on the self. Thus through regression, it becomes narcissistic libido. Through introjection (reinstatement of the object within the ego) the object remains within the ego. Identification may be the sole condition on which the id can give up its objects. The result is that the ego then assumes the features of the object; and says to its erotic id, 'Love me. Look! I'm just like your former love (the object)'. Identification is thus an ego function, one of those ego functions that gives mastery over the id.

In healthy identifications, sublimation takes place. The ego is able to relinquish the object as an object; libido is then turned back into primary narcissism; desexualized; and the ego becomes stronger by absorbing that part of the object's personality into its own. Freud (1923) has said it forms that part of the superego called the ego ideal. I think the ego ideal probably is more than a part of the superego, probably it is a strong part of the ego itself. These might be examples of healthy identifications: the son of a doctor identifies with his father and becomes a doctor; a daughter identifies with her mother and becomes a mother and housewife. In normal

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* Freud was the first to use oral incorporation, he said the ego 'devoured' the object. He says this is a primitive cannibalistic form of identification.

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identification, the developmental stages in order are: (1) autoerotic, (2) primary narcissism, (3) partial object identification, (4) sublimated object identification.

PATHOLOGICAL IDENTIFICATIONS

In the process of pathological identification the object is still eroticized. The amount of eroticization and the number of pathological identifications determine the degree of sickness. For instance, in an hallucinating schizophrenic there is little healthy identification formed and the object must be magically fantasied. In catatonia the lack of movement, curling up posture and so forth is reminiscent of the womb state. In the womb before birth, no identifications have yet been made. The lack of object attachment found in catatonic states has even prevented pathological identifications from forming. The instincts are strong and growth is fixated at the autoerotic stage. The autoerotic stage of infancy appears before the primary narcissistic stage. It is purely instinctual and automatic, and even one's own body is not known as an object.

Pathological identifications are formed from partial object cathexis. Whenever an object is eroticized, transference exists. The amount of transference (transference is an instinct derivative) is directly proportionate to the amount of eroticization that exists and inversely proportionate to the amount of healthy sublimation that has occurred. Theoretically this is so, but clinically speaking, I must say that I have never seen a person in whom complete desexualization of the object has occurred. A healthy personality is measured by the degree of sublimation. This would explain why Rosen (1954) has said that schizophrenics have a large capacity for transference. Cathecting an object in schizophrenia is accompanied by a high degree of eroticization.

I think that next we should theorize on what causes pathological identifications. I have said that identification is primarily an oral procedure. Regression takes place to the oral phase. I will use a mother as the object,

since in infancy the mother or mother substitute is with the baby most of the time. The infant has instinctual needs. When the lips are eroticized and sucking motions are made, primary narcissism or the stage of eroticization of the self already exists. Sucking motions have been noted even before birth. If the object, the mother, feels the babies' instincts with her own maternal instinct, the roots and pathways for object cathexis are formed at once and early. If the mother's maternal instincts are not flowing easily, the baby will feel this. Frustration will occur and there will be withdrawal of libido from the object. If there is no other object available it goes back into the self and becomes narcissistic. If this occurs too early, where the instincts have not been sufficiently satisfied, fixation of the libido occurs. No, or little, sublimation occurs. All through life, through the process of transference, this instinct will seek satisfaction. If partial object cathexis has occurred, as in pathological identification, the instincts are still not satisfied but are able to seek out new objects more easily than if no object cathexis had occurred. In more severe psychosis complete object withdrawal occurs. The object here may be hallucinated or projected through a delusion. Thus regression has approached to almost an autoerotic stage. The body is not eroticized as in primary narcissism. Clinically this is demonstrated in severe psychosis such as the catatonic and hallucinatory states. In paranoia, depressions, hysteria, obsessive compulsive neurosis, hypochondriacal states and anxiety reactions there is partial object cathexis and so pathological identifications are formed. Of course, clinically, one sees mostly mixtures of all these states combined. So, if the mother has her own unfulfilled needs, she is not prepared to give herself to the infant. She is hostile and frustrated. I think that the degree of these feelings in the mother will determine the severity of illness in the offspring. Ignore constitutional qualities; it is known that some infants can get more from the source of supply than others.

CLINICAL EXAMPLES OF PATHO-
LOGICAL IDENTIFICATIONS

Let us review the process of identification again in the treatment situation. In therapy, identifications are revealed, and the therapist, in order to guide the patient's ability to have good judgement, must have a sense of what is pathological and what is normal. For instance, J.B. is a 21-year-old male, a recent graduate from art school who has recently been sworn into the army reserve. Soon after, on consultation with his general physician, I saw him in a general hospital. He was hallucinating God and talking to images in the room. He would shout 'Mom, Mom where are you?' His face was twisted with anxiety. He was incontinent. His pyjamas and sheets were wet. I answered, 'Whom are you looking for?' This made him pensive and he turned his head in my direction, obviously noticing that I was in the room. I then asked him questions, purposely, to focus his attentions on me as the object. 'Do you feel like you are floating? Can you feel your body? Hold my hand!' He withdrew, I asked: 'Does that make you feel queer?' He answered: 'Yes, I feel like a little girl. Mom, Mom where are you? My chest is swelling. My God! I have breasts! I feel I have to do something. There is something I must do immediately but I don't know what. God if I only knew!' Then turning to me; 'Please, do you know?' I answered him: 'Yes, you want to be a woman, a mother, and nurse your baby!' He looked at me again. Obviously the answer had penetrated. There was a long pause. Then 'God I feel lonely, empty inside.' I took advantage of several things that I knew about identifications to make these interpretations. The boy had an anxious, searching face. His eyes were wandering all over the room. He was at the earliest stages of psychosis. Depersonalization and estrangement had taken place. He was beginning to hallucinate an object. He reminded me of a wet and hungry baby in his crib. His cry for mother demonstrated something Freud (1923)

had said: 'First identification in earliest childhood will be profound and lasting.' The boy had formed partial object cathexis and was trying to rebuild from the fixation point. However, when his mother who was there with us in the hospital came into the room, her presence was meaningless to the boy. He still called for his mother. Obviously, the object he was calling was an object cathected when he was an infant. My interpretations were meaningful to him. Through these interpretations I was more closely approaching his infantile object, than was his somewhat bewildered and anxious mother who was there too. I was understanding his needs. I was becoming the early object—the infantile mother. It is interesting that at this stage, I have had patients see me with large breasts. His next statement was: 'I feel like a little girl, I have breasts.' This meant to me that he was projecting his mother on to his self. This was an early identification with his mother. Before he could form an identity as a boy or man he had to identify as a woman. This was a partial identification and a pathological one for him. In therapy, however, I recognized it as a normal developmental stage and accepted it. Suppose I had not said, 'You want to be a woman and nurse your baby', but had instead said, 'That's silly, you aren't a girl, you're a man', the statement, although correct, consciously would not have been understood. One can thus see how understanding the process of identification is important in therapy. His last statement, 'I feel empty inside', showed his lack of healthy identification. My answer was, 'I will fill you and you will be strong like me.' So in this one hour he had progressed from beginning hallucinatory psychosis to beginning identification with me, the new object. He would have to recathect me as the object, redirect all his libido on to me throughout therapy, before he could form healthy lasting identifications by the process of sublimation.

So far I have kept away from Freud's theory of the development of the superego. This has been done in order to eliminate

confusion. Freud has said that superego formation reaches its apex with the passing of the Oedipus complex. Then again, Melanie Klein says that the superego sets in as early as the second half of the first year. There is no doubt that the superego is involved in the formation of a pathological identification. Freud (1924) has stated: 'The child's ego turns away from the oedipus complex. The authority of the father, or parent, is introjected into the ego and there forms a kernel of the superego which takes its severity from the father, perpetuates its prohibitions against itself and so insures the ego against re-occurrence of the libidinal object cathexis. Libido trends belonging to the oedipus complex are in part desexualized, sublimated, which probably happens with every transformation into identification; in part they are inhibited in their aim and changed into affectionate feelings.' So in a pathological identification there still exists a large part of sexualized object libido in the ego. Along with this remains a strong inhibitive superego. The superego prevents further satisfaction of the instinct with the object. If sufficient in degree this (remembering the instincts necessary for the process of identifications are pregenital and mostly oral) will inhibit further identification. The object does not become desexualized, and little further sublimation is achieved.

M. L. is a 41-year-old divorcee who shows the formation of a pathological identification that exists alongside of a sadistic superego. She has been under therapy for three years. At first, being catatonic, she was treated in hospital. Soon, she emerged from her psychosis and was able to live alone. Although having a room in a hotel, she prefers being alone and travelling alone. She prefers meeting people superficially and attempts to make her identifications this way. She rejects her family, her brother-in-law and older sister. The girl was raised in a German family before the war. The father was a banker and the mother concerned herself with flowers and afternoon tea. The girl is obsessed with proper manners and constantly talks about being brought up as a lady. She values people on these counts alone. She does not like scientists because they have bad manners. She wants to meet a young lawyer or business man with a Harvard education. She, thus, would be sure of his good manners and her proper attentions. Thus the object, her mother imago, still is cathected, but at a degree to inhibit her movements and preoccupy her thoughts. A strong superego, in turn, punishes her, by not letting her vary from the internalized identification.

The strongest resistance to cure is the transference. Many people in therapy, almost consciously it seems, will not give the therapist up as an object. The female patient will try to get the therapist into a genital relationship. The male patient will try to keep the therapist in a latent and inaffectual passive homosexual relationship. There seems to be no interest in the therapy, but only in the therapist. If it would be remembered that identification is essentially an oral, and certainly a pregenital process, the therapist soon finds out that by concentrating on ways to fulfil these pregenital needs, he would be doing his patient more service in the long run.

The following list of cases demonstrates pathological identifications with the infantile mother image as the object:

(1) Freud's (1911) description of the Schreber case is filled with examples of pathological identifications. One morning, while in the state between sleeping and waking, the idea occurred to Schreber, 'after all it really must be very nice to be a woman submitting to the act of copulation'. Freud writes: 'This idea is one which he would have rejected with the greatest indignation if he had been fully conscious.' To my way of thinking it represents a very early, perhaps primal scene identification with the mother, perhaps from the age of two or three. It is an example of partial object cathexis, and was obviously terrifying to Schreber and not accompanied by any feminine affection. Thus it might be called a pathological identification. Schreber said again: 'I have a feeling that great numbers of female nerves have already passed over into my body,

and out of them a new race of men will proceed, through a process of direct impregnation by God. Not until then, will I be able to die a natural death and like the rest of mankind, have regained a state of bliss.' In the meantime, not only the sun, but the trees and birds, which are in the nature of 'miracled relics of former human souls', speak to him in human accents, and miraculous things happen everywhere around him. I would interpret this as an attempt to hallucinate and delude not only Father (sun) but Mother (birds and trees).

Schreber says further: 'The male state of bliss is superior to the female, which seems to have consisted chiefly in an uninterrupted feeling of voluptuousness. Voluptuousness may be regarded as a fragment of the state of bliss given in advance, to new and other living creatures. So that the state of heavenly bliss is to be understood as being in its essence an intensified continuation of sensual pleasure upon earth! Voluptuousness stands in a close relationship to the state of bliss enjoyed by departed spirits.' This is perhaps in an identification with his mother.*

It is interesting that Freud entertained the idea that paranoia might turn out to be the 'negative case', that is, a case in which sexuality plays only a minor part.

Schreber goes on: 'If I press lightly upon any part of my body, especially in the regions of the chest, where, in a woman, her breasts would be, I'm able to evoke a sensation of voluptuousness, such as women experience and especially if I think of something feminine at the same time. It has become so much a habit with me to draw a female buttocks on to my body—that I do it almost involuntarily every time I stoop. Anyone who should happen to see me before the mirror, with the upper portions of my torso bared, especially

if the illusion were assisted by my wearing a little feminine finery—would receive an unmistakable impression of a female bust.' The doubt in Freud's mind was justified. How often do we seek genital symbols as a defence against oral needs? Why is Schreber so concerned about busts and buttocks and not genital symbols? I'm sure, with a little stretch of the imagination, one may visualize that when stooped, a woman's buttocks may simulate breasts in appearance.

(2) J.D., a 17-year-old graduate, listened to the television set about the Berlin crisis and heard and felt that Kennedy wanted him to go to the White House to join his 'unofficial family' of advisors. The boy was familiar with psychoanalytic concepts and offered his own interpretation. His reasoning was that Kennedy was the father of our country and that he wanted to be near his father figure. I was not satisfied with this explanation and I offered my own. I said, 'you wanted to go to the White House because it offers the finest grade A milk.' He grasped my equation of White House and white milk and became extremely anxious, fuming, 'You think you know it all! You think that I'm looking for a mother!' It was obvious that my interpretation had touched upon something basic. He was trying to ignore memory traces of a pathological identification of earlier life.

(3) Another patient, K.W. age 47, confided some of his thoughts: 'I was thinking of a cow's udder in my rectum.' In free association he continued; 'I think I have tits... I think my wife isn't a good enough mother to my kids.' On another day he said, in free association, 'I want to suck your penis.... I have a thought of my mother....I want to suck her tits; I see them with sugar....I was at a party last night....I thought of sucking other women's tits at the party—then I thought I had tits....I had a feeling I was losing my manhood.' I answered; 'It's obvious that you want to be a woman, a mother.' I then said: 'Before a man becomes a man, he has to be a woman.'

(4) B.L. is a 24-year-old weight lifter,

* Freud (1923) mentions bi-sexuality in identifications and speculates on its origins. In my opinion duplicity of identifications occurs when there is partial identification with woman and partial identification with man. This would explain the frequent association of an image of a woman with large breasts and also a penis.

almost all his thoughts are of his body. His desire is to be Mr America. His weight lifting occupies all of his energies. He is unable to seek gainful employment. His wishes are to win a Mr America contest then open his own gym. His mother once won a beauty contest when she was young. He has voluntarily shown me a picture of her taken at the time of the contest. In one session he said: 'I visualize myself in intercourse, my stomach is out and it looks like a vagina. I can't get the feeling of a cock and balls below.' At this time he was obsessed with the thought that his stomach muscles were enlarged. He worked hard with the weights on his stomach muscles. He became depressed and said it was all to no avail. But, compared to my own, his stomach was very flat.

(5) D.M. was a 50-year-old pants presser who was having psychosomatic symptoms. 'I have a kicking-like feeling in my abdomen.' He was the only offspring so I asked if his mother had ever given birth and then lost the baby when he was a child. He could not recall but when he went home and asked his wife, she told him that his mother had lost a baby girl when he was three.

(6) E.W. was a 35-year-old auto mechanic. He remembered making mud breasts as a child. His associations followed. 'My grandmother bumped her breast and developed cancer of the breast. My mother spent all her time with my grandmother and not us kids. Maybe this is why I have this chest pain.'

(7) A.M. is a 19-year-old single female who has a delusion that she 'lays air'. She says it has come out of her rectum continuously since she was in the fifth grade. People avoid her because of the odour. On street cars and in public places she hears people whispering about her. There is no pleasure in life for her—but she cannot change. This is the punishment she must endure for committing her sin. She constantly clings to her mother, she goes everywhere with her, although there is very little other communication between mother and daughter. The mother is concerned with A.M., and although the father has been dead three

years, and the mother is still relatively attractive, she cannot go out with men because of this great concern for her daughter. The mother is depressed, feels unworthy, and is greatly obsessed with cleanliness and odours about her own person. She, however, denies any responsibility for the daughter's condition and says that she loves her daughter and has told her so. One can see how the mother's unconscious feeling of unworthiness about herself has influenced A.M. The result is a feeling in A.M., that (1) Mother says she loves me and so she must; but (2) I feel a lack of something, a feeling of being unloved. (3) If mother loves me, it must be my fault if I feel this way. (4) It must be because I smell, that people react to me the way they do, and why I feel the way I do. Mother's concern with odours and smells has led to the formation of a pathological identification in A.M. with her mother.

(8) Another patient, B.W., age 28, married, has one child of seven and an adopted girl of five. The patient was suicidally depressed. She felt that she was 'rotten inside'. She had had surgery seven times, including a hysterectomy at the age of 24. She was the last of five children and was born when her mother was 44 years of age. She has had eczema since she was three months of age. Her earliest memory was of her mother saying: 'I wish and pray that God may take you if this horrible rash doesn't leave.' This was after one of her frequent journeys to one of many hospitals to have her eczema treated. In seven months of analysis she had seven hospital admissions, the first three were for abdominal pain, nausea and dehydration, which her surgeon diagnosed as further adhesion formation. She had her first abdominal attack after the disappearance of her eczema at the age of 14. The analysis revealed that the operations were a device by which she tried to remove the rottenness from her body. Gynaecological examination revealed that she suffered from endometriosis. However, both before and after surgery, the pain was referred up under the costal arch in the gastro-duodenal area. Somehow the

feeling of being rotten was an oral incorporation and identification. She describes her mother as having been an excitable person who was of little help when she, while growing up, had need of a mother. Whenever she had a problem, instead of getting from her mother what she needed, she would end up consoling and comforting her mother lest the mother should collapse. She recalls that only in hospitals and with doctors did she know a feeling of safety. It is interesting that she trained as an X-ray technician, worked in a hospital and when she married she persuaded her husband to go to medical school. The mother was weak, ambivalent and her low self esteem was conveyed to her daughter at an early age, as if it came from the milk itself. 'Rotten milk produced rotten insides.'

The next example shows how a pathological identification may cause a loss of reality that almost ended in death.

(9) L.L. is a 40-year-old housewife, who one day told her daughter to put a plastic bag over her head. The 11-year-old child became frightened and the woman was admitted to a general hospital where I saw her in consultation. She was calling her mother and crying and was obviously in extreme anxiety. She thought she heard her mother calling her and telling her to join her. The only difficulty was that her mother had been dead nine years. She told me she had been lonely and empty. Her husband was an alcoholic. She had an affair with a 30-year-old bachelor but her guilt feelings prevented her from continuing. Several visits later, when she was feeling better, she said she felt that she had been reborn and that I was her new life.

Women frequently identify with their fathers in a masculine way. This may be a very early identification, and may only be with an organ. Thus it is a partial object identification, which is pathological. Thus V.O., age 21, thought she had a large nose, she would get bursting headaches in which she felt that her eyes were popping out and her nose was swelling larger. Only a nose bleed relieved the pressure. The nose symbolized the penis in erection.

FINAL DISCUSSION

I mentioned in a previous paragraph that in therapy it is necessary to distinguish a budding healthy identification from a fixed pathological identification. Actually both are partial object cathexes. However, the budding identification is flexible and will grow into a healthy identification while the pathological identification (unless worked with vigorously) will remain fixed.

In the process of growing up, object relationships may be treated in different ways. This may well serve as stages of growth of budding identifications. Melanie Klein has outlined this clearly. Abraham (1924) has also written on this subject. Klein (1934) writes: 'The nature of a child's object relations and character formations is very strongly determined by whether its predominate fixations are situated in the oral sucking or oral sadistic period. The introjection of a kindly mother leads to setting up a friendly father imago, owing to the equation of breasts with penis. In the construction of the superego, too, fixations in the oral sucking stage will counteract the terrifying identifications which are made under the supremacy of oral sadistic impulses.'

In the relationship to objects, one may: (a) withdraw from the object and hallucinate it. This happens in severe psychosis. (b) Turn toward it with greater positive feeling. The mother imago is split into good and bad objects. The mechanism of projection is used to accomplish this. Usually the bad object is projected on to the real world, this is a further step in object relationships. This occurs in paranoia. (c) Be abstracted, treated and controlled; as in obsessive compulsive neuroses. (d) Be railed against, depreciated, made to suffer with sadistic verifications derived from its suffering—as in depressions. (e) As the individual approaches the genital stage he employs restitutive mechanisms and reaction formations of pity for the objects. This is accomplished only when the ego feels strong enough and secure in dealing with the

object. In the therapy of psychosis we may see all stages develop, in the above order, with the therapist as the object.

In direct analytic therapy, several new rules are introduced to aid healthy identification formation. The therapist, unlike the classical psychoanalyst, offers himself as an object of identification deliberately. He does this by injecting his opinions and value judgements. The psychotic, as mentioned previously, is void of object cathexis, proportionate to the degree of sickness. First the therapist concentrates on the removal of the psychotic defences ('the hallucinatory object cathexis'). Rosen (1953) has mentioned ways this has been done.

The patient shows, by various signs, that the treatment is successful and that the therapist is being incorporated. The patient may vomit. I always interpret this as an ejection of the bad object. Symptoms subside. The anxiety lessens. The patient, who before felt depersonalized and had delusions of the end of the world, may say, 'I feel reborn.' Probably even before this he admits to feelings of emptiness and loneliness. If you ask him how he feels at this stage, he usually says: 'Sort of like standing still, I am waiting, I enjoy my visits with you—afterwards I feel better.' This is ideal for therapy. The therapist is like the mother, his very presence represents oral gratification to the patient. Incorporation and basic identification processes are at work. When the patient has had sufficient oral gratification to stop the hallucinations, his symptoms become anal in character; this character structure Rosen has called the neo-neurosis. Now

therapy is more classical in approach. Progress is slow. The work is tedious. Through the transference, old pathological identifications arise. The patient continually seeks out old object memories from the past unconsciously. He attempts to make the therapist act like his old objects. This must be pointed out to the patient. At this stage the patient may be working and living almost a normal life. Other people in reality have become objects of identification, where previously it had only been the therapist and his assistants. Office visits may be regulated just to periods of anxiety 'build up' or are on a regular basis. I use both methods, depending on what the patient needs. But I do insist on follow-up treatment. If the patient is able to confide his pathological thoughts, in due time, with conscious effort, the patient may overcome his pathological identifications. The repetition compulsion makes progress tedious and it takes time for new identifications to form. It is most important in many cases to win over the mother (original object cathexis). If this can be done, therapy that might have failed, may have a satisfactory outcome. In normal growth of the ego (as in the growing child) partial object cathexis are continually being made. In the therapeutic process this occurs too. If therapy is discontinued fixation will occur with the therapist as the object and a pathological identification may be formed. Time and frequent contact with the object is important for the formation of healthy identifications. When such identifications have been made with the therapist, the bond between therapist and patient becomes everlasting.

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Seven principles to overcome resistances in hypnoanalysis

By RAYMOND N. ANTEBI*

The use of indirect methods, as a principle for investigation and treatment in the course of hypnoanalysis, has been mentioned by several authors in the past. Hypnoanalytic techniques have been and are still being used by the Freudian analyst but given a broader connotation they could be used by any hypnotist in the course of psychiatric treatment, as a means of uncovering deep-seated conflicts, repressed painful experiences and precipitating factors of neurotic illness in general. Hypnoanalysis and hypnotherapy are often without a distinguishing boundary, so much so that it seems impossible for us at times to separate these two entities. The obvious fact that an abreaction under hypnosis could result in the solution of a neurotic illness does not exclude an adverse effect in other patients where it is the beginning of further needs and conflicts which will require time in order to allow the patient to 'work through'.

In other words, the integration of hypnoanalysis and hypnotherapy can be so intricated that it is only with careful management of this treatment that we can expect satisfactory results.

DIRECT METHODS USED IN HYPNOANALYSIS AND HYPNOTHERAPY

The direct method is used by many hypnotists and is a rather unsatisfactory means of obtaining valuable material. Hypnosis is said to be a heightened state of suggestibility and therefore the therapist's behaviour is of primary importance. It is a simple observation that with our eyes closed we can easily be induced to build an *auditory image* of the person communicating with us which will depend on the pitch, tone and timbre of his

voice, the cadence, rhythm, inflexion and speed of his sentences. Reasoning by analogy where the hypnotized subject has a narrowing of consciousness, it is logical to assume that the *auditory image* will be intensified as the means of communication is restricted. The corollary that follows, is that the patient will be hypersensitive in his responses to the therapist's demands. Any insecurity or anxiety of the therapist will be betrayed in his voice and the content of his talk, and this undoubtedly will affect the patient's response and will modify his resistance accordingly. Direct questions fired at the patient by the anxious hypnotherapist are likely to increase the patient's resistance, especially if the material is deep-seated and guilt-producing. Obtrusive demands from the hypnotist can, by producing a resistance in a patient, mislead the former on a side track.

Resistances under hypnosis take similar forms to those resistances in psychotherapeutic relationships, with the exception of the sequence of principles involved. For example one will find denial of obvious facts, rationalizations and projections at a childish level. In order to overcome these resistances the therapist could by-pass part of his own anxieties by having recourse to the indirect methods.

INDIRECT METHODS USED IN HYPNOANALYSIS AND HYPNOTHERAPY

A review of the literature on this subject is significant in so far as many authors have used one or other method, but no scientific principles or guidance have yet been established.

Janet, Prince, Sidis, Muhl, Wells and others have explored some of these specialized

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techniques. The most extensive application of these have been made by Erickson who combined a unique inventiveness with a shrewd and intuitive grasp of the patient's psychological status. He used these methods as the essential levers of his therapy.

Brenman & Gill (1948) used specialized hypnotic techniques such as regression and direct suggestion of dreams, either in the hypnotic state, or post-hypnotically as part of the patient's natural sleep. The use of various devices to obtain material inaccessible to consciousness, such as the artificial implantation of a temporary conflict, have been mentioned by these authors. For example, a patient is induced to experience vivid visual images by suggestion. He is made to see a single word written on a blackboard which will provide a clue to the problem at hand. An alternative technique is suggestion to the patient that at the count of 5 a number will occur to her. The significance of this number is that it will specify the number of letters in a word which will provide a key to the question under consideration. In one instance quoted by Brenman & Gill (1948) the patient's answer was 4. The individual letters were obtained in a similar way; M. O. B. W., and the four letters were rearranged. The patient spelt 'womb'.

Erickson (1933) employs almost every possible technical device, including free association, automatic handwriting, crystal gazing, dream suggestion, or underlining the significant letters in the process of reading to overcome resistances.

Le Cron & Bordeaux (1948) in their book discuss the value of hypnosis in hypno-analysis: 'To thwart resistances some indirect methods are employed': for instance, the hypnotized patient is told that he will be able to think of a significant word or perhaps a number of jumbled letters, which will make up a key-word. Visual hallucinations on the count of 5 have been induced. Other methods such as automatic handwriting, drawing, crystal or mirror gazing have been found of value.

Erickson & Kubie (1941) found age regression to be useful, Muhl (1924) and Prince (1925) combined automatic handwriting with crystal gazing as a means of recalling forgotten incidents.

Wells (1944) used similar indirect methods, Wolberg (1946) mentions a variety of techniques which he utilized, including free association, dreams, phantasy stimulation, mirror gazing, automatic handwriting, play therapy, dramatic acting, regression, revivification and the production of experimental conflict. Moreno (1937, 1939) used psychodrama extensively under hypnosis as well as regression and revivification. In another article Erickson (1933) postulates the existence of a third level of consciousness having been unsuccessful with direct and indirect approaches. He used indirect techniques to obtain forgotten material in such a way that their true significance was not recognized by the patient.

Watkins (1949), Klopfer & Kelly (1942) and Beck (1944, 1945) used the Rorschach Test as a projective technique. Thematic Apperception Test, dream induction, drawings, finger paintings, sketches, free association, have also been used.

One of the most interesting depth techniques is dissociation or splitting of the personality structure into two or more segments for separate study.

As a result of a questionnaire sent to various therapists Fromm-Reichmann & Moreno (1956) found that most of the hypnotherapists used free association, dream induction and various exploratory techniques. Least used were induction of experimental conflict and play therapy. Regression and revivification were spontaneously mentioned by some therapists as their preferred method. It may seem that therapists have preference for different techniques. They conclude that significant material may be elicited by any technique, if the therapist has confidence in what he is doing and performs his task with appropriate skill. However, some patients seem attuned to certain methods rather than others. For

example, a patient may communicate better by drawings than by free associations, whereas another may respond more satisfactorily to induced experimental conflict, or to Erickson's technique of time distortion and pseudo-orientation in time and space. Experimentation will show which hypnoanalytic method is most appropriate to a particular patient or special situation.

PRINCIPLES USED IN THE INDIRECT APPROACH IN THE COURSE OF HYPNOANALYSIS AND HYPNOTHERAPY

(1) Distortion of the time concept.
(2) Distortion of space concept.
(3) Dissociation of the personality.
(4) Link in the dissociation process.
(5) Induced changes of the emotional state.
(6) The process of concretization.
(7) Distortion of the body image.

For the purpose of elucidation the summaries of three case histories are presented here to which references will be made during the elaboration of the principles involved.

Case I

A 31-year-old unmarried female nurse was admitted to hospital because of drug addiction, alcoholism and insomnia of 13 years standing.

On admission she was secretive, depressed, suspicious, cynical and sceptical about her treatment. Supportive psychotherapy, drugs and electro-convulsive therapy were attempted, all to no avail. Eventually 16 sessions of hypnoanalysis disclosed various traumatic experiences in early childhood and in adulthood which were totally repressed: i.e. rape at the age of 4 by three men in a train lavatory, attempted seduction by her father a short time after, violent accidental death, possibly suicidal, of her boy friend in a car crash following a lover's quarrel in which he threatened to kill himself 13 years previously. She identified herself with Oscar Wilde's prisoner in the 'Ballad of Reading Gaol'—

And all men kill the thing they love,
By all let this be heard,
Some do it with a bitter look,
Some with a flattering word,
The coward does it with a kiss,
The brave man with a sword.

She felt that she had a destructive power, an 'evil genius' over those she cared for. She also gave four instances of close relationships which she had enjoyed but which had terminated tragically. The environment thus produced an emotionally withdrawn woman with a need to escape and a consequent dependency upon drugs and alcohol. Nevertheless, her working capacity was unimpaired until a few months prior to admission. She had high standards and excellent references throughout her nursing career.

This patient has been working now for the past 13 months as a Health Visitor, after a period of 7 months' hospitalization. She has considerably improved in her capacity for relationships. No recurrence of her addiction was evidenced in the last interview. Her insomnia has been treated by teaching her self hypnosis. After a period of 10 weeks the sleep rhythm reverted to normal and no self induction was required.

Case II

A 34-year-old married naval steward was referred because of total blindness of sudden onset whilst preparing the 6-monthly inventory of mess equipment.

He was treated with 6 weekly hypnoanalytic sessions as the history did not reveal any obvious precipitating factors. The following sequence was uncovered under treatment.

The blindness occurred within a matter of 2 to 3 hours following a question put to him by his supervisor. 'Have you seen the candlesticks, John? I can't find them in the cupboard.' His reply was 'No'.

It transpired that a few weeks before he had given the key of this cupboard, which was part of his responsibility, to one of his friends. He was aware that the latter intended to steal and sell the candlesticks valued at about £40,

The deed was perpetrated and a reward of £5 was handed over to the patient.

This patient showed hysterical features in the past history. He related after his improvement an incident which occurred in 1947 in India when he again was an accomplice in a carpet theft; the same pattern emerged. At that time he was in charge of a storeroom and purposely left the key on a table. The key was 'found' by his mate, the carpets were stolen and his reward was 1500 rupees. He was arrested 3 days afterwards on suspicion of having been connected with the theft. A sudden generalized skin rash and sycosis helped him to evade questioning. He spent 2 months in a hospital for this ailment. No charges were preferred against him due to lack of evidence.

He presents an overall picture of a dependent personality.

This patient has gained insight and fully recovered his vision. He has remained well for 2 years after his 3 months of hospitalization.

Case III

A 34-year-old married Insurance Clerk was referred because of his asthma.

His first asthmatic attack began at the age of 6 when he raced his elder brother home from school. He won the race but was breathless on arrival. A few hours later his local practitioner diagnosed an asthmatic attack with bronco-spasm.

He thereafter had several mild asthmatic bouts until he reached his 21st birthday. The reason for this improvement has not been uncovered. He was free from further attacks until 11 years later. At that time he had a major row with his brother. Since then he has suffered from severe asthmatic bouts, four of them requiring hospitalization. His hostility against his brother was overt. His rejection by his mother who preferred the other brother was also conscious.

Asthmatic attacks were produced during the hypnotic sessions and were controlled with the count down from 10 to 1 by the therapist in the first instance, then by the patient himself. He succeeded partially in controlling his serious asthmatic attacks when not hypnotized.

The treatment had to be interrupted after 16 sessions as the therapist left the hospital.

He has greatly benefited from this treatment and has had two attacks of bronchitis without wheezing, confirmed by his local practitioner.

The seven principles will now be studied in detail.

(1) Distortion of the time concept

It is possible to vary the time concept of the hypnotized person by appropriate suggestion. This can be combined with dream induction as a time-saving device. It can also be used in regression and revivification. The notion of time can be altered at the hypnotist's convenience, provided an ideal therapist–hypnotized subject relation is achieved. Ten minutes can be transformed into either 10 seconds or 10 hours according to the needs of the therapist.

Example case I

Under hypnosis the patient was told that she would dream of certain events for a period of 5 minutes. This dream taking place over a count of 5. The patient was thereby induced to believe that each count represented 1 minute, whereas in fact it represented 1 second. It took her several minutes to relate the dream content.

Another common way of distorting time is to suggest a change of date to the past or the future, regression being a common procedure for investigating the patient's past. On the other hand, hypnotized patients can be made to think of themselves on a specific date in the future, when it is suggested to them that they will be symptom-free. The therapist will therefore be able to draw his own conclusions about the primary or secondary gains of the patient's symptoms.

A patient who complained of various aches and pains for a duration of 3 months was hypnotized. It was suggested to him that the

date was 1 month hence and that he would be symptom-free.

He was told that he was comfortably seated in an armchair before the fire. He was asked 'how do you feel?' and replied 'on top form'. After a short preliminary discussion he was asked if he had any worries as he was showing signs of restlessness. He admitted that the thought of his forthcoming marriage was foremost in his thoughts. This was thereafter used by the therapist to explain his physical discomforts.

(2) *Distortion of space concept*

By appropriate suggestion one can easily induce the hypnotized subject to visualize different surroundings which could be known to the patient or altogether new to him. This method is used in dream induction, crystal gazing and regression.

An illustration of this method is as follows: It was suggested to a patient that he was in his own home comfortably relaxed in the sitting room armchair. His wife came in, and an argument started. From what followed, the conversation being repeated word for word by the patient, one could study in a natural setting the patient's reaction as well as the wife's attitude towards him.

(3) *Dissociation of the personality*

This principle seems a vital one in order to enable the hypnotist to uncover repressed conflicts.

The indirect methods used are projection of images on a screen, on a television, on a crystal ball, or on a cinema screen. Other methods are dream induction and automatic handwriting. The aim of the therapist is to reduce the anxiety associated with the repressed memory. The deeper the conflict the more dissociation will be required to bring it out. One can learn by experience that the complex phenomenon of dissociation is a relative concept. Dissociation varies with the level of awareness even in the deeply hypnotized subject.

Example case II

The object was to uncover the name of his confederate. Under hypnosis it was suggested to him that he should summon up a mental picture of a blackboard on which would be written the required name(s). He claimed that the board was blank and was unable to produce the required name(s) by direct suggestion. By inducing further hallucinations he was however able to see a hand writing in a meaningless order. These letters were only seen under a high-powered lens, another induced hallucination. It was suggested that these letters would drop one by one into a hat at the bottom of the board where they would be mixed and catapulted back on the same board in the right order. The names were then obtained.

Example Case I

Direct questioning under hypnosis to obtain further information with regard to her insomnia did not yield any results, but she was able to describe a film entitled 'The Woman Who Could Not Sleep'. This 'dream film' was induced hypnotically, the interpretation of it was not forthcoming by the patient. It was then suggested that the therapist would go with her to the producer of the film (who, incidentally, was another person connected with her experience) and would ask him what the point of the film was. Again the answer yielded no salient information, but when the therapist taught her to hypnotize the producer, which she did after a good deal of encouragement, the interpretation was clear to her, and she slowly superimposed herself on one of the actors claiming that it was her own experience.

The film related the history of a pilot who was flying at high altitude. A failure in the intercommunication system caused the pilot to panic. As a result of this, the plane crashed, the pilot was killed and the female co-pilot escaped with a severely injured and bloody hand.

The relation of this dream to her insomnia

and her traumatic experience 13 years previously was self-evident.

In dissociating the personality further, one can, if the subject has reached the stage of complete dissociation, obtain an accurate account of the facts.

(4) *Link in the dissociation process*

It seems important, whilst using the previous technique of dissociating the personality, to preserve a continuum between aspects of the personality which have been dissociated.

All the complex phenomena which are created between the hypnotist and the subject, will influence the latter with regard to his power of dissociation. A complete dissociation can be exploited by the subject to his advantage, and result in a therapeutic resistance, and a wrong lead may be given to the therapist at the same time. It is worth while at this stage to introduce a link connecting the two or more aspects of the dissociated personality in some way. For example, the common factor in the distortion of time and space is the individual himself. This common factor has been found to facilitate the emergence of repressed memories.

Example case I

The patient was induced to have a dream in the early stages of her treatment. The dream was produced, but presented only in a slightly disguised form her present conscious anxieties; it was therefore suggested to her that the title of a dream film would be 'The Woman Who Could Not Sleep'. No dream was produced at that stage, but when the therapist took her out of the cinema, to read the names of the actors, one of them called Ruth Smith (Ruth being the christian name of the patient) a dream film was produced which symbolized her basic needs and her unresolved conflict.

Example case II

A visual image of a hand-writing on a blackboard was induced. This hand would write a keyword related to the presenting symptom.

The word was only produced after it was suggested that his own name (John) would be written in a corner of the blackboard.

When, how, and where, the link should be introduced is a difficult decision to make. What the link should be is also a matter of individual judgement; the symbolic significance of this link should be determined by the total aspect of the relationship between the patient and the hypnotist, by the depth of the trance, by the suspected degree of guilt resulting from a traumatic experience and by the power of dissociation of the patient.

(5) *Induced changes of the emotional state*

Whether the basis of an acute neurotic illness is the outcome of a repressed emotional state, consisting of negative feelings such as pain or fear, or the result of a traumatic experience, or whether the negative feelings follow by contrast a pleasant experience, is still a matter for conjecture. At any rate the production of a state of heightened tension either by direct suggestion or by suggestion aided by hallucinations based on irrelevant stimuli with regard to the patient's illness, has proved to be of use in producing useful material.

For example, a patient may have a number of situations or stimuli which arouse his anxiety, some of which are unconscious. By inducing a state of increased anxiety by direct suggestion, the patient may associate such situations with his state of tension and this in return will facilitate its coming into consciousness. The therapist having full knowledge of the patient's history and symptoms will sometimes be able to guide the latter in the associative process.

Example case III

The patient was hypnotized but could not recall how and when his first attack started. When his tension state was gradually increased by direct suggestion and subsequently indirectly through the induction of a concrete scene in which the patient was made to argue

with his brother, he showed signs of distress and recalled the day he raced his brother from school.

(6) *The process of concretization*

This process has been used much more on an intuitive basis by hypnotists. Its importance cannot be stressed enough as without it hypnoanalysis conducted in the above way would be useless.

The hypnotized patient according to the psychoanalytic view is in a regressed state. Along with this regression one would expect the subject to use more concrete thinking as opposed to abstract mentation. This assertion seems to be substantiated by clinical experience. Hypnotized patients can, with appropriate suggestion, be hallucinated through any of the five senses. The fact that these artifacts have to be used in order to circumvent resistances denotes a need for them in the patient.

The different techniques used in hypnotic induction are always based on concrete suggested references, such as abnormal bodily sensations, i.e. numbness, infallible movement aberrations of one or more parts of the subject's body, i.e. body sway, arm levitation technique.

The rhythmic monotony of mechanical devices, used as adjuncts to achieve a heightened state of suggestibility, is well known to the hypnotist. It has been used also by the primitives, and is still in vogue in certain religious sects. The head banging or the rocking of the infant to induce his sleep is another example. Children often need a pleasant type of hypnotic induction, supported by the suggestion of amusing and enchanting dreams.

A suggested concrete change in the subject's emotional state, or the induction of images conducive to a change in the affective state, are two key devices which will allow the hypnotist to communicate with his subject on a common ground, the latter being the same pre-verbal emotional communication used by the child.

It might well be that the different degree of conceptualization potential of two individuals is the operative process which prevents adequate communication, creating therefore complicated inter-relational factors.

In obeisance to the above hypothesis the hypnotist should use words or induce primitive emotions which are not involved in highly conceptualized thinking in order to avoid resistances.

It is well known, for example, that some will refuse to undress in the course of a hypnotic session on direct command, but will do so if the suggestion, aided by hallucinations that they are to take a bath in their bathroom by themselves, is forcefully presented. Dream induction, screen viewing, revivification, Thematic Apperception Test cards, are just different approaches employing much the same principle.

In order to better understand the process of concretization one must diverge for a while and study in general terms the process of concept formation and its relation to certain mental illnesses.

A concept seen from a dynamic angle can be unbalanced by emotions, and if deviant enough from the norm, can be the basis of a psychiatric disability. It seems therefore important to examine a concept as closely as possible and one should endeavour to trace the origin of its constituent parts. This entails the study of abstraction in the first place, gradually leading to more and more specific concrete representations. By doing so, the emotional factor in the concept can be dissociated from it, and if need be, the patient could be taught to reconstruct a concept on an emotion-free rational basis.

A simple experiment which was tried on a patient will illustrate the great need of concretization under hypnosis. A patient was asked to say what the word dog meant to him. He mentioned in the first place that it was an animal with four legs, a head and a tail, he proceeded thereafter to particularize spontaneously and gave a clear description of a certain dog.

Example case III

The asthmatic patient already quoted was able to produce attacks of bronco-spasm under hypnosis. These attacks were induced much more quickly when a concrete picture in which he saw himself racing his brother home was suggested to him, than when his anxiety was increased by direct suggestion 'you are feeling more and more tense now'.

It seems therefore that the patient's own need for concretization may be constructively utilized in the analysis of a concept, assuming that the latter has been distorted and is at the base of the patient's disability.

(7) Distortion of the body image

Regression to earlier stages of life with the appropriate distortion of the body image has been known to occur for many years. Regression to an early age with an extensor plantar reflex is a known fact, and similarly handwriting and drawing in different ages also demonstrate body image distortion.

Example case II

The patient was told that his body would be so small that he would be able to pass through the keyhole of a shop door. The subject had developed a strong resistance against this shop. It was always closed when he passed by, the keys were lost, and in the shop window was a large poster on which he could clearly read 'Closed until further notice'. The resistance was self explanatory only after he entered through the keyhole. In fact it was a second-hand shop in Plymouth and the candlesticks were displayed in the shop window.

Distortion of the body image is also well known to the dermatologist who uses hypnotic treatment. Under such treatment the production of physical changes in the skin in relation to the degree of anxiety has been proved already in the past. Any improvement in the original skin condition may lead to the substitution by another symptom whether mental or physical if the underlying conflict has not been dealt with adequately.

Unfortunately the dynamic concept of body image is as yet so indefinite that its application in hypnotherapy is difficult to assess. Hypochondriasis, pains of psychological origin, need further investigation and research in the hypnotic field.

DISCUSSION AND SUMMARY

The importance of the creation of an *auditory image* of the hypnotist cannot be over-emphasized in hypnoanalysis and hypnotherapy. This *auditory image* will form the foundation of any relationship between patient and therapist. Seven principles to overcome resistance in hypnoanalysis have already been described.

The successful use of these methods is dependent upon a shrewd and intuitive grasp of the patient's psychological and emotional needs. A sound knowledge of the theoretical principles which govern certain neuroses will allow the therapist to make concrete assumptions. These in turn will give rise to a limited train of inquiry which may help to set the patient on the road to the source of his illness. Those therapists who have experience in the use of hypnoanalysis and hypnotherapy are aware of the limitation of hypnosis as an aid to the treatment of mental illness. The difficulty arises from (1) the type of neurosis suitable for this treatment, and (2) the relatively few patients who prove to be good hypnotic subjects. At the same time it could be of immense value not only for the treatment of the patient but also as a method of research into concept formation in the individual.

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The Babcock sentence in clinical practice

By J. W. WARBURTON*

INTRODUCTION

The Babcock sentence was introduced into clinical practice by Zangwill (1943), having been adapted by him from the Babcock Repetition Test (Babcock, 1930). In its correct form it reads: 'One thing a nation must have to be rich and great is a large secure supply of wood.' It is used as a test of rote learning, i.e. learning by repetition regardless of meaning and without any attempt at organization (Drever, 1960). The sentence is repeated alternately by examiner and patient until the latter is able to reproduce two consecutive word-perfect repetitions. Zangwill (1943) suggested that failure to do so after eight attempts indicated an organic memory retention defect, providing the patient was not psychotic and above the defective level of intelligence. He also suggested that the test was of value qualitatively, in that the nature of the errors made by the patient was often of additional help in indicating a brain lesion. Nevertheless, he indicated quite clearly that the sentence had not been standardized for age and intelligence: there does not seem to be any evidence in the literature that this has yet been done. Despite this, however, the test has gained a certain popularity in clinical practice, perhaps because of simplicity of administration.

About a year ago the present author began to use the sentence as a screening test in the pre-operative assessment of patients undergoing thalamotomy for the treatment of Parkinson's disease. It was soon apparent that the majority of the patients had great difficulty in learning it. In a group of 25 only 3 were able to reproduce two correct repetitions before the eighth attempt. Their ages

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ranged from 40 to 65 years and each had a performance on Raven's Progressive Matrices above the twenty-fifth percentile. Although a degree of dementia is a common finding in the later stages of the illness this seemed a surprising finding in a group of patients who were otherwise suitable for surgery. In view of this, it was felt that it would be of interest to administer it to a larger group of patients who were in hospital for less serious reasons.

METHOD

Forty male and 40 female patients were tested. These were further divided on the basis of age into four subgroups: 21–30, 31–40, 41–50, 51–60. The patients were taken from medical, surgical and gynaecological wards. Fifty-seven had been admitted for routine surgical or gynaecological procedures. All in this group were tested prior to operation. Any patient thought to be suffering from a neurological or psychiatric condition was excluded. In addition to the Babcock sentence the patients were asked to learn two other nonsense sentences. These were adapted from Joyce's *Ulysses* and read as follows:

(1) 'Your name entered for life in the book of the Union'. (2) 'What did Stephen see on raising his gaze to the height of a yard from the fire'. The first was shorter and easier than the Babcock, the second of approximately the same length. It was hoped that the latter would be of about the same degree of difficulty but in fact proved to be slightly easier. The patients were asked to learn in the order

> Sentence 1.
> Babcock sentence.
> Sentence 2.

They were then asked to complete the Progressive Matrices in order to satisfy the

Table 1. *Failures*

	No.
Patients failing to learn Babcock sentence after 8 attempts	32
Patients failing to learn all three sentences	15
Patients failing Babcock sentence able to learn sentence 2	5
Patients reproducing Babcock sentence and failing sentence 2	3
Patients making one predominant repetitive error	8

Table 2. *Details of failures*

Age	Sex	P.M.	D.S.	S. 1	B.S.	S. 2
21	M.	50	8	F.	F.	F.
23	M.	25	8	C.7	F.	F.
32	F.	50	7	C.2	F.	F.
35	F.	75	7	C.6	F.	F.
37	M.	75	7	F.	F.	F.
38	M.	25	6	F.	F.	F.
38	M.	25	7	C.4	F.	C.7
40	F.	25	7	F.	F.	F.
42	M.	90	8	C.1	F.	F.
44	M.	50	7	F.	F.	F.
45	M.	50	7	C.2	F.	C.6
47	M.	90	8	C.1	F.	F.
47	F.	95	7	C.5	F.	C.7
48	F.	50	6	F.	F.	F.
49	M.	25	7	F.	F.	F.
49	F.	90	7	C.6	F.	F.
50	F.	90	6	F.	F.	F.
52	M.	25	6	F.	F.	F.
52	M.	50	7	C.3	F.	C.5
52	M.	50	7	C.6	F.	F.
53	M.	95	8	C.2	F.	F.
55	F.	25	7	F.	F.	F.
55	F.	90	8	C.5	F.	F.
57	F.	50	7	F.	F.	F.
57	F.	50	6	F.	F.	F.
57	F.	90	6	F.	F.	F.
59	M.	90	6	C.7	F.	F.
59	M.	25	7	F.	F.	F.
60	M.	95	6	C.6	F.	F.
60	M.	75	6	C.5	F.	C.5
60	M.	90	7	C.8	F.	F.
60	M.	95	9	F.	F.	F.

P.M., Percentile rating on the progressive matrices; D.S., Digit span; S. 1, Sentence 1; B.S., Babcock sentence; S. 2., sentence 2; F., failed at 8th attempt; C., Correct at ... attempt.

criterion that the patient should be above the defective level of intelligence.

RESULTS

There did not appear to be any marked difference in the type of errors made when these were compared with those reported by Zangwill (1943). In all age groups the male patients appeared to have more difficulty than the female (see Tables 1 and 2).
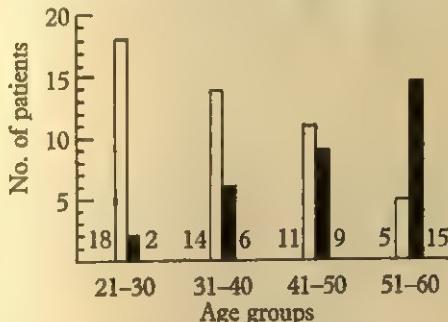
Fig. 1. Nomogram of failures and successes in relation to age groupings. ■, Patients failing to learn after 8 attempts. □, Patients succeeding at or before the 7th attempt.

DISCUSSION

The results seem to suggest that age is a more important factor than intelligence (as measured by the Progressive Matrices) in learning by rote, but it is significant that the five patients in the age group 51–60 able to reproduce the sentence correctly were of high intelligence.

Patients over the age of 40 appear to have more difficulty with this type of test than is generally realized. This is of interest when one notes that most of the patients originally tested by Zangwill (1962) were under the age of 40. The reasons for this are presumably complex and related to such factors as loss of capacity to learn and loss of adaptability in performing an unusual task. One was also struck by the degree of emotion engendered in the older patient after repeated failure. This was particularly marked in the male subjects who tended to regard their failure as a loss of face.

On the basis of these findings, the usefulness of the Babcock sentence, or any other test of rote learning of comparable difficulty, would appear to be limited to the second and third decades. Thereafter, the number of failures among a normal hospital population increases too sharply for it to be of any great value in the detection of an organic retention defect.

SUMMARY

The Babcock sentence, together with two other tests of rote learning, was administered to 80 patients in hospital for reasons other than neurological or psychiatric. Thirty-two failed to learn it after 8 attempts.

It is suggested that the usefulness of the test is limited to the second and third decades.

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A note on intelligence and date of birth

By T. G. CROOKES*

Orme (1962) has recently produced data in support of the notion that intelligence is related to date of birth, in that people born in the months of May to October tend to be more intelligent than those born in the period —November to April. These two periods will, for convenience, be referred to as 'summer' and 'winter' respectively. The data used were the I.Q.'s and birth dates of a group of subnormal individuals. It was predicted that the higher I.Q. range (55–69) would contain a greater proportion of people born in summer than those in the lower range (40–54). This prediction was borne out at a high level of significance.

However, since the findings were thought to be relevant to the question of I.Q. and birth date in general, not just to subnormals as a special group, and since the subnormals constitute the lower end of the intelligence distribution, there is a further expectation, if the hypothesis is to be supported; namely, that the subnormal group as a whole should contain a greater number of winter births than would be expected by random sampling from the whole population. As the numbers of people born in summer and winter are almost equal (*Registrar-General's Statistical Review of England and Wales*, Part II, Civil, table TT, any year), the subnormal group would be expected to contain an excess of winter births. This is not so, in the figures quoted; there are in fact, in the whole group, rather more summer than winter births (78 to 70), and in the upper I.Q. group there is a considerable excess of summer births (48 to 30, $\chi^2 = 3.71$, P is just over 0·05). This makes it very difficult to understand the significance of the results

for the relationship of intelligence and birth date in general.

To make a quick check on the relationship for people of normal intelligence, the records of children tested at a child psychiatric clinic were used. These are children tested routinely in the years 1953 to 1959; the distribution of I.Q.'s is close to the normal, with some excess of high scores. It is difficult to think of any interaction between I.Q. and birth date which could affect the likelihood of attendance at a clinic, so this seems a reasonable group with which to test the hypothesis. Those with I.Q. below 70 were excluded, as were those below the age of 5, because of the unreliability of the scores below that age. This left a group of 474 children aged 5–0 to 15–11. Of these, 205 had been tested on the Terman-Merrill, the remainder on the Wechsler-Bellevue or W.I.S.C.. These tests have good correlation with each other (Koch, 1954). The mean I.Q.'s of the children born in summer and winter, boys and girls shown separately, are given in Table 1.

Boys and girls are given separately to show the similarity of seasonal means within each sex, although there is a considerable difference between sexes ($t = 3.178$, $P < 0.01$). This incidental finding suggests an interaction between sex and I.Q. in child guidance referral.

Comparison of summer and winter means gives $t = 0.337$, $P > 0.7$. Thus, the results accord very well with the hypothesis that over the normal intelligence range there is no relationship between I.Q. and date of birth. This allows us to avoid the difficulty of relating Orme's data to intelligence in general, since it appears that the relationship he found is something peculiar to subnormals. If so, the reasonable assumption is that it applies to subnormals of the 'pathological', rather than

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Table 1. I.Q. *by sex and season of birth*

	Summer			Winter			Total		
	No.	Mean I.Q.	S.D.	No.	Mean I.Q.	S.D.	No.	Mean I.Q.	S.D.
Boys	165	109·63	16·34	147	109·02	16·30	312	109·34	16·30
Girls	84	104·32	17·53	78	104·28	15·22	162	104·30	16·42
Total	249	107·84	16·94	225	107·33	16·05	474	107·62	16·49

the 'subcultural', type. The findings of Pasamanick (1962) and his colleagues seem to fit in with this view; for instance, the increased incidence of toxemias and bleeding in mothers delivered in the winter months. They found also that the occurrence of the third month of gestation in July and August only led to an increased risk of subnormality in summers of above average heat, which suggests a critical value of this heat effect, leading to an all-or-none result. To explain the whole of Orme's results, it would strictly be necessary to suppose differential seasonal relationships operating in the factors causing 'pathological' subnormality, such that those leading to more severe defects were more likely to occur in winter babies, the less severe in those born in summer. This is more unlikely but not inconceivable.

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